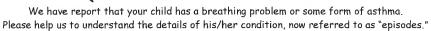


### Stillwater Area School District #834

# **ASTHMA**

# Questionnaire and Medication Orders



Student's name		Date of Birth	Grade/Teacher
Parent/Guardian		Homephone	
Phone (Mom)	(Dad)	Physician name_	
	911 transport needed) attempted first; before tran		he event of an emergency, contact with a
b. How severe was the f c. When was the last tin d. How severe was this l e. If applicable, how ma f. How many days did yo	ne your child experienced an ast episode? (circle) MILD ny episodes required either h ur child miss school last year has your child's asthma ever	MODERATE SEVERE Emerge episode? (date):	nt care during the past year?
Smoke Grass/flowers Stress or emot	Animals/pets Mold ional upset	ther triggers? YES NO If so, Dust/dust-mites Chalk/chalk dust Changes in weather/very Exercise, sports, or playi Any other triggers:	Cockroaches Strong smells/perfume cold or hot air
b. Does your child know c. Have any allergy shot		5 NO Please list types:	DOD None
4. What are the pre-wai	rning signs (physical & emotio	nal changes) that indicate that y	our child may be having an asthma episode?
_	•	having an actual episode? (ie. W	/heezing, cough without relief, respiratory
b. Does your child recog	nize when he/she is having an	n episode? (circle) YES	NO
		cations taken at Home	
Medication name	How much	and how often?	When is it taken?

Student name:	Date of Birth:	-			
For Health Care Provider: Please complete this section:  Medications to be taken at School					
Medication name and route	How much (dose) and how often?	When is it taken?			
vs. prn; Additional medications during illr	sode: be specific: (ie: bronchodilator before physicss.) A detailed Asthma Action Plan (AAP) for this student's AAP to this questionnaire in order	sical activity or cold weather recess; scheduled times this student will provide the school with the needer for the school to administer medication.			
c. Is student inhaler proficient? YES	nister their inhaler (grade 6-12+) YES NO	uired for their inhaler? YES NO oes student need assistance? YES NO			
Physician/NP/PA signature		Date			
Clinic Name Clinic Phone Number					
·	what action do you advise the health office	to take?			
8. It there anything else you would lik	e to add about your child's breathing?				
ordered by my child's physician/licens stopping of medication, etc.) I give pe prescriber regarding any questions the	ed provider. I will notify the school of any crmission for the school nurse to consult wit	ondition and medication if used. Medications			
	o be able to carry and take their own asthm ol personnel from liability in the event adver of the health room.				
My child will sign and follow the se	elf-administration of asthma medication stu	dent agreement.			
Parent/Guardian Signature		Date			



# Self-Administration of Asthma Medication (Grade 6 – 12+)

### **Student Agreement**

Ιa	g	re	e	to	:
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- 1. Follow my prescribing health professional's medication orders.
- 2. Use correct medication administration technique.
- 3. Not allow anyone else to use my medication.
- 4. Keep a supply of my medication with me in school and on field trips.
- 5. Notify the school health office personnel if any of the following occurs:
  - My symptoms continue or get worse after taking the medication.
  - My symptoms reoccur within 2-3 hours after taking the medication.
  - I suspect that I am experiencing side effects from my medication.

	• Other					
<b>5</b> .	. I understand that permission for self-administration of medication may be suspended if I am unab					
	naintain the procedural safeguards established above.					
	Signature of Student	Date				
	Name of Student	Birth Date:				
	School:	Grade:				
	**	(6 – 12+ only)				