MISSOULA COUNTY PUBLIC SCHOOLS

Forward Thinking, High Achieving.



Asthma/Inhaler/Nebulizer Medication Parent Information

Dear Parent:

We give this letter to parents if their child has an inhaler at school to treat asthma or breathing problems and/or you gave information that your child has asthma or breathing problems.

Please do the following so that your child is safe at school.

1. Have your child's doctor/healthcare provider fill out and sign the attached "Asthma/Quick Relief Bronchodilator Form" every year.
2. Add your signatures to the form.
3. Take the form and any needed medications to your child's school at the start of the school year; it is better to do this several days BEFORE the start of school. Be sure the medication is NOT expired.

ADDITIONAL INFORMATION:

- Notify the school of any allergies, other health conditions or changes related to health.
- Make sure the school office has your current phone and address.
- For students with asthma, the school nurse adds a computer "health alert" to let your child's teachers know your child could have asthma breathing difficulties. The nurse also provides the teachers with standard first aid information about asthma.
- The health department has a nurse who specializes in asthma and can help you and your child with asthma control. See back of this page for more Information.
- If you feel that your child may need additional "accommodations", ask the school or school nurse to "evaluate for 504 accommodation plan" eligibility if your child does not already have a 504 plan. This involves permission forms and a school meeting.
- "Lock downs", "perimeter lock-ins" or school evacuations: There are many reasons any of these events may occur during the school day including planned drills, "false alarms", fires, earthquakes, storms and real or the threat of a dangerous individual in the area. Schools are dynamic places. At the start of an event, your child may be in their classroom, on the playground, in a hall or bathroom or other area such as the lunchroom or cafeteria. When safe to do so during an evacuation, staff will retrieve emergency medications kept in the office. The safety of all students is always the priority. I wanted to alert you to the reality that the only way your child will always have ready access to their emergency medication, no matter the type of event, is to wear it on themselves at all times. You may choose to instruct your child to keep their emergency medication on them at all times and we will note that on accommodations plans. If you choose to do this, it would be best to have your child do this at all times, in and outside of school, so that it becomes a lifelong habit.
- For students who self-carry and self-medicate for their asthma medicine, teach them to always have the medications with them, to tell an adult right away if they used any medicine and it is not working well, to keep medicine in a safe place and not to share their medicine.

Please call me if you have any questions or concerns. Thank you for working with the school so your child is safe and ready to learn!

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Missoula County Public Schools partners with the local health department to help ensure students are healthy. This program has helped many children live better with their asthma. Initial visits can be done somewhere other than the home if needed and completion is always the family's choice. If your child has any of points listed under "Eligibility" or the following, please consider this program.

- Your child misses more than 1 day (or two partial days) of school every 1-2 months because of their asthma symptoms.
- Your child is not always able to exercise due to asthma symptoms.
- Your child's sleep is affected by asthma symptoms.
- Your child uses their quick acting inhaler (like albuterol) 2 or more days a week not including taking before exercise preventatively.

Call the health department number directly (258-4290) to have this program.

You may also tell the school nurse you would like a referral to this program. Note: signed release needed to go through school nurse.

Form revision June 2020

Asthma/ Quick Relief Bronchodilator Medication Authorization

Student Name: _____ Date of Birth: _____ Grade: _____

Known triggers: ☐ Exercise ☐ Upper Respiratory Infections ☐ Other:

HEALTH CARE PROVIDER SECTION:

Is student diagnosed with asthma or reactive airway disease? ☐ Yes ☐ No
Any ER visits or hospitalizations for asthma in last 1-2 years? ☐ Yes ☐ No

Preventative: Pre-treatment of medication and dose named below before strenuous activity:

- ☐ Routinely
- ☐ Upon request: Explain (weather, viral, seasonal, other):_____
- ☐ Not needed or not applicable

- May repeat in 4 hours if needed for additional or ongoing physical activity.

Other:

Mild to Moderate Symptoms:

1. For asthma episode/ breathing difficulty symptoms : Use this quick acting medication:

Albuterol ☐ 1 puff ☐ 2 puffs ☐ Other dose: _____ *(Albuterol = Proventil, Pro-Air & Ventolin)*

Other: _____
Medication name/ Dose/ Other such as per nebulizer if applicable

2. If symptoms return within a few hours, repeat above medication. Notify parent.

3. If symptoms continue but ARE NOT SEVERE, may repeat above medication once in 20 minutes. Notify parent.

Severe Symptoms: (continual coughing, struggling to breath, and/or trouble talking)

1. ☐ **2 puffs** ☐ **4 puffs** ☐ **6 puffs** of above inhaler medication ☐ **Other dose/med:**_____
Medication name/ Dose/ Other such as per nebulizer if applicable

2. CALL 911 then call parent and school nurse.

3. Repeat above dose if Emergency Medical Services have not arrived within 10 minutes.

☐ Permission for student to self-administer**:** I confirm this student has been instructed in the proper use of the medication listed above and is able to self-administer without school personnel supervision.

☐ Permission is **not given** for student to self-administer without supervision.

_____ _____ _____ _____
Sign*ature of Health Care Provider* (Physician, PA or APRN) **Date (valid for 12 months)** **PRINTED NAME** **Phone Number**

PARENT SECTION: Please sign below

FOR ALL STUDENTS

- I give my permission for my child named above to take the above medication at school as ordered.
- I understand that the medication will be given to my child or their use supervised by a school nurse or a school staff member unless the child has permission to self-medicate.
- I agree to doctor (health care provider) and school nurse communication based on this medical order/permission if needed. Communication, if needed, may only include the medication or treatment itself, implementation of the treatment in school and student outcomes of the treatment.
- I understand it is my responsibility to provide medication and to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.
- I understand that the schools may share this information to appropriate school personnel and classroom teachers.

⇨_____/_____
Parent or Guardian Signature **Date (valid for 12 months)**

FOR STUDENTS WHO HAVE HEALTH CARE PROVIDER PERMISSION TO SELF-MEDICATE:

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call. I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort. I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma emergency. I have provided backup medication. I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

⇨_____/_____
Parent or Guardian Signature **Date (valid for 12 months)**

***Office Use Only**: _____ Q order entry/ _____ Q 1st Aid handout attached/ _____ MAR in office/ _____ 1st aid handout w/ inhaler (4/16 form)*