



Dear Parents,

According to our records, your child has asthma, or has had asthma medicine at the school in the past. It would be helpful to have updated information about your child's asthma so we can plan for the care of your child at school. Enclosed is an **Asthma History** form requesting updated information about your child. Please complete it and return it to the health room before the start of the next school year.

If your child needs to take medication during school hours or at school sponsored events next year, please have your health care provider complete the **Health Care Provider Medication and Treatment Plan for Asthma** form. Bring the completed Health Care Provider Medication Request and Treatment Plan for Asthma with the Parent Permission signed with the medication in a properly labeled container when school begins in the fall.

Please contact Health Services or your School Nurse if you have any questions.

Sincerely,

School Nurse



Bethel School District
ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

Person completing this form: _____ Date: _____

Parent/Guardian Name: _____

Primary Phone: _____ Work Phone: _____

Alternate Contact: _____ Phone: _____

Healthcare Provider Managing Asthma: _____ Phone: _____

When was this student first diagnosed with asthma? _____

How many times has this student been seen in the emergency room for asthma in the past year? _____

How many times has this student been hospitalized overnight for asthma in the past year? _____

Has this student ever been admitted to an intensive care unit for asthma? YES NO

If yes, when? _____

Please circle the number that best describes the severity of this student's asthma?

NOT SEVERE 1 2 3 4 5 6 7 8 9 10 SEVERE

How many school days would you estimate this student missed because of asthma last year? _____

What triggers this student's asthma?

- Exercise Stress Pollen Wood Smoke
- Respiratory Infections Strong odors or perfumes Molds Indoor Dust
- Temperature changes Carpets Cigarette Smoke Outdoor Dust
- Animals: _____ Other: _____
- Foods: _____

Please list known allergies: _____

What does this student do at home to relieve asthma symptoms (check all that apply)?

- Breathing Exercises Rest /Relaxation
- Takes Medication (see below) Drinks Room-Temperature Water
- Other (describe): _____

Is an Epinephrine Auto-Injector prescribed for this student? YES NO

Please list medications this student takes for asthma (daily and as needed):

MEDICATION NAME	AMOUNT	DELIVERY METHOD	DAILY	HOW OFTEN DAILY?	AS NEEDED

What herbal remedies, if any does this student take for asthma? _____

Does this student use any of the following aids for managing asthma?

- Valved Holding Chamber Spacer Device
 Valved Holding Chamber with Mask Peak Flow Meter (personal best if known) _____
 Other: _____

Please check special needs related to this student's asthma (check all that apply):

- Avoidance of certain foods Physical Education Class Animals in the classroom
 Access to water Recess Field Trips
 Transportation to and from school Observation of side effects
 Other: _____

If you checked any of the above boxes, please describe needs:

Has this student had asthma education? YES NO

I am interested in additional asthma education for: MYSELF MY STUDENT

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____



SCHOOL YEAR	SCHOOL	FAX

Student Name: _____ has asthma and may need to take medication at school.

The treatment plan for managing asthma at school is as follows: (Check all that apply)

- Diagnosis:** Intermittent Mild Persistent Moderate Persistent Severe Persistent
 Administer rescue medication if student experiences symptoms (*coughing, difficulty breathing, wheezing, chest tightness*)

DRUG & DOSAGE FORM	DOSE, TIME, AND MODE OF ADMINISTRATION
<input type="radio"/> Albuterol Inhaler <input type="radio"/> With Spacer	<input type="radio"/> 2 (or ___) puffs by mouth 5-20 minutes prior to exercise, as needed (<i>may repeat with 2</i>) <input type="radio"/> 2 (or ___) puffs by mouth every 3-4 hours as needed for symptoms <input type="radio"/> If no relief after treatment, call 911 and notify appropriate staff <input type="radio"/> Other:
<input type="radio"/> Combination Inhaler <input type="radio"/> Budesonide-formoterol <input type="radio"/> Mometasone-formoterol <input type="radio"/> Budesonide-albuterol <input type="radio"/> Other:	<input type="radio"/> 1 (or ___) puffs by mouth 5-20 minutes prior to exercise, as needed (<i>may repeat with 2</i>) <input type="radio"/> 1 (or ___) puffs by mouth every 3-4 hours as needed for symptoms <input type="radio"/> If no relief after treatment, call 911 and notify appropriate staff Other:
Nebulizer Treatment Type <input type="radio"/> Albuterol <input type="radio"/> Levalbuterol <input type="radio"/> Other:	<input type="radio"/> 1 unit dose every ___ hours as needed for symptoms <input type="radio"/> May repeat and call 911 <input type="radio"/> Other:

- Student has been instructed in use of device needed to administer medication
 Student has demonstrated the skill necessary to use the medication appropriately.
 Student recognizes symptoms of asthma and will seek assistance if needed.
 Student may carry and self-administer the medication ordered above.
 Other: _____

Health Care Providers Signature	Phone (<i>for clarification on orders</i>)	Fax
Health Care Provider's Printed Name or Stamp	Date	

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY	
Parent/Guardian's Permission:	
I request that the school nurse, principal, or designated staff member be permitted to administer to my child (<i>name of child</i>) _____ or allow my child to carry and self-administer as indicated above, the medication prescribed by (<i>name of provider</i>) _____ for the _____ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by the school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or legal guardian of the child named.	
Parent/Guardian Signature: _____	Date: _____
Parent Contacts: <i>Home:</i> _____	<i>Cell:</i> _____ <i>Work:</i> _____ <i>Other:</i> _____

STUDENT DEMONSTRATES SKILL NECESSARY TO SELF-ADMINISTER MEDICATION AS ORDERED ABOVE.	
School Nurse Signature: _____	Date: _____



Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

Student	Student Name: _____ Birth Date: _____ _____												
Released By	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student												
Released To	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student												
Purpose	For the purpose(s) of: <input type="checkbox"/> This information may be used or disclosed in connection with mental health treatment/services and healthcare operations. <input type="checkbox"/> Other purposes (specify each purpose): _____ _____												
Information to be Disclosed	Description or nature of information to be used and/or disclosed: (check all that apply) <input type="checkbox"/> Assessment/Intake Summary <input type="checkbox"/> Psychiatric Reports <input type="checkbox"/> Service/Treatment Plan <input type="checkbox"/> Progress Report <input type="checkbox"/> Safety/Crisis Plan <input type="checkbox"/> Other records(specify): _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;"> Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released. </td> </tr> <tr> <td style="padding: 5px;"> Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released. </td> </tr> </table>	Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.	Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.								
Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.												
Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.												
Notices	I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.												
Expiration	I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period: Date: _____												
Signatures	I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Signature of student</td> <td style="width: 60%; border-bottom: 1px solid black; text-align: center;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Signature of legal/personal representative</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship to student</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%;">Update of Authorization</td> <td style="width: 40%;">Signature 1: _____</td> <td style="width: 35%;">Date: _____</td> </tr> <tr> <td></td> <td>Signature 2: _____</td> <td>Date: _____</td> </tr> </table>	Signature of student	Date	Signature of legal/personal representative	Relationship to student	Date	Date	Update of Authorization	Signature 1: _____	Date: _____		Signature 2: _____	Date: _____
Signature of student	Date												
Signature of legal/personal representative	Relationship to student												
Date	Date												
Update of Authorization	Signature 1: _____	Date: _____											
	Signature 2: _____	Date: _____											