NATOMAS UNIFIED SCHOOL DISTRICT

Asthma Management for the School Setting

Last Name:_____ First Name: _____
School Year:_____ Effective Dates:_____
Date of Birth (mm/dd/yyyy):_____ Medical Record #:_____
School Name:_____ School Contact Phone #:_____
Parent/Guardian Name:_____ Parent/Guardian Phone #: _____
Emergency Contact:_____ Emergency Phone #:_____
Health Care Provider Name:_____ Health Care Provider Phone #:_____

Attention Parent/Guardian/School Personnel:

ANY student with asthma (of any severity) can have a severe asthma attack.

***The following information is to be given by the health care provider*:**

Asthma Severity: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent
Asthma symptoms are triggered by: ❑ Exercise ❑ Dust ❑ Animal Dander ❑ Strong odors or fumes ❑ Mold
❑ Other: _____
Current Health status:_____

Asthma Management at school:

Medication Name: _____ Dose/Puffs:_____
When to administer:_____
Instructions for administration:_____
Possible Side Effects:_____

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When to administer:_____
Instructions for administration:_____
Possible Side Effects:_____

Is student competent in self administering medication? ❑ Yes ❑ No
Is student competent to carry medication at school? ❑ Yes ❑ No

Other orders/instructions from physician:_____

Restrictions/Limitations for Activity (list if any): _____

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

_____/_____ _____
Name Signature Date
Phone: _____ **Fax:** _____

Parent/Guardian (Authorization and Disclaimer): I request that the school assist my child with the above asthma medications and asthma action plan in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer asthma medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of asthma medications.

_____/_____ _____
Name Signature Date