



VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

Health Services

16350 Mojave Drive, Victorville, CA 92395-3655

Phone: (760) 955-3201 ext. 10427 Fax: (760) 257-1010

VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

STUDENT ASTHMA INFORMATION SHEET

Student name: _____ ID: _____

Describe type of symptoms student experiences (i.e., wheezing, coughing, etc....)

Date of last asthma attack _____

About how often does student have an attack? daily ___ weekly ___ monthly ___ yearly ___

What usually causes or triggers attack? (exercise, stress, weather, illness, etc.)

Medications student takes: Name, dose, frequency:

Side effects of medication that your student experiences:

Does your student use a peak flow meter? _____

If so, what is the student's current best peak flow? _____

Does your student use a spacer for their inhaler? _____

Additional information/instructions:

Parent/Guardian Signature: _____ Date: _____

Symptom Based – Asthma Action Plan

School Phone # 760-955-3201
School Fax # 760-257-1010

Student Name: _____ Date of Birth: _____ School: _____
Parent/Guardian: _____ Home Phone: _____ Cellular: _____

The following is to be completed by the PHYSICIAN (Items #1, 2, 3, and 4):

1. Medication(s) (taken at school AND home):		Please CHECK box if needed for use at school.
A. "QUICK-RELIEF" Medication Name	1. _____	<input type="checkbox"/> For School *
	2. _____	<input type="checkbox"/> For School *
B. ROUTINE Medication Name (e.g. anti-inflammatory)	1. _____	<input type="checkbox"/> For School *
	2. _____	<input type="checkbox"/> For School *
	3. _____	<input type="checkbox"/> For School *
C. BEFORE PE, Exertion: Med Name	1. _____	<input type="checkbox"/> For School *
	2. _____	<input type="checkbox"/> For School *

2. For student on inhaled medication (all students must go to Health Office for oral medications)

- Assist student with inhaled medication in Health Office*
 May self-administer/self-carry inhaler medication. * Student demonstrates competence. (**Not** recommended in elementary school)

3. A spacer device (e.g. Aerochamber) use is advised for all students at school.

4. Check known triggers: tobacco pesticides animals birds cockroaches cleansers car exhaust perfume
 candles mold dust cold air exercise smog pollens other _____

5. Using the SYMPTOMS below, determine the appropriate ZONE and follow the action indicated:

Green Zone

Symptoms: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities

Action for school:

1. Give "Quick – Relief" Medication(s)*
2. Notify Parent if symptoms are NOT relieved by medication after 15 - 20 min
3. If symptoms are NOT RELIEVED follow School Emergency Plan below
4. If symptoms are relieved, student may return to class
**Notify Parent if "Quick – Relief" inhaler has been used more than two times this week (if not related to physical activity)*

YELLOW ZONE

Symptoms: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions

Action for school:

1. Give "Quick – Relief" Medication(s)
2. If symptoms are not improved within 15 to 20 minutes by student's "Quick – Relief" medication, or symptoms become worse, follow School Emergency Plan below

RED ZONE

Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restrictions, symptoms are the same or worse after 30 minutes in Yellow Zone

SCHOOL EMERGENCY PLAN

1. **REPEAT** "Quick-Relief" medication(s) now
2. **Call 911** – Seek emergency care
3. Contact parent/guardian and school nurse
4. REPEAT "Quick-Relief" medication(s) in 20 minutes if help has not arrived and symptoms have not improved
5. Stay with student until paramedics arrive

Physician Name: _____ Physician Signature: _____ Date: _____

Address: _____ Phone: _____

City: _____ Zip: _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ Date: _____ Phone Number: _____

School Phone # 760-955-3201
School Fax # 760-257-1010

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication (*prescription or over-the-counter*) can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

Student Name: _____ Date of Birth: _____

PHYSICIAN USE ONLY

1. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____

Route: Oral Nasal Topical
 Inhale Injection Other _____ Med Start Date: _____ Stop Date: _____

If DAILY - Time(s) to be given: _____

If AS NEEDED (prn) ~ Frequency: Every 3 to 4 hrs., Every 4 to 6 hrs., Other : _____

*Self carry - for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.
o (Not recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____

Route: Oral Nasal Topical
 Inhale Injection Other _____ Med Start Date: _____ Stop Date: _____

If DAILY ~ Time(s) to be given: _____

If AS NEEDED (prn) ~ Frequency: Every 3 to 4 hrs., Every 4 to 6 hrs., Other : _____

*Self carry - for asthma Inhaler or epinephrine auto-Injectors ONLY. Student demonstrates competence.
o (Not recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____ Phone: _____

City: _____ Zip: _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

**Parent Request
For Assistance with Medication at School**

B. The parent or guardian must complete this page before any medication (*prescription or over-the-counter*) can be given, or taken, at school. **Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.**

Student Name: _____ **Date of Birth:** _____

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ **Date:** _____ **Phone Number:** _____

B. For **ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY** requests only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ **Date:** _____ **Phone Number:** _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.



Authorization for Use and/or Disclosure of Information

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
School Site: _____ LEA of Residence: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ E-mail Address: _____

AUTHORIZATION

I authorize the individual/agency named below to disclose the above-named student's medical and/or educational information to the receiving LEA as indicated under this Authorization.

DISCLOSING AGENCY
Individual/Agency DISCLOSING Information: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Contact Name: _____ Phone: _____ E-mail Address: _____

RECEIVING AGENCY
Individual/Agency RECEIVING Information: Victor Valley Union High School District
Street Address: 16350 Mojave Drive City: Victorville State: Ca Zip Code: 92395
Contact Name: Julie Dieppa, RN Phone: 760-855-3201 Ext. 10427 E-mail Address: jdieppa@vvhhsd.org

I agree that the Individuals/Agencies above may mutually share information.

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

REVOCACTION: I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this Authorization.

REDISCLASURE: I understand that educational health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

HEALTH INFORMATION: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to assure medical treatment.

SPECIFY RECORD(s):

- Medical/Medication Mental Health/Psychiatric Drug/Alcohol
 Educational Records STD/HIV Test Results Other: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (Date)
or for one year from the date of signature if no date is entered.

I request that the information released pursuant to this Authorization be used for the following purposes:
 Educational Assessment Educational Planning Other: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: _____ Date: _____
Student Signature: (if applicable) _____ Date: _____