



VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

Health Services

16350 Mojave Drive, Victorville, CA 92395-3655

Phone: (760) 955-3201 ext. 10427 Fax: (760)483-7966

VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

FORMA DE INFORMACIÓN DEL ASMA DE UN ESTUDIANTE

Nombre del (de la) estudiante: _____ # ID: _____

Describe el tipo de síntomas que experimenta el / la estudiante (ej., jadeo, dificultad para respirar, tos, etc....) _____

Fecha del último ataque de asma _____

¿Cuál es la frecuencia con que el / la estudiante tiene un ataque? Diaria ___ semanal ___
mensual ___ anual ___

¿Qué suele causar o desencadenar un ataque? (ejercicio, estrés, clima, enfermedad, etc.)

Medicamentos que toma el / la estudiante: Nombre, dosis, frecuencia:

¿Cuáles son los efectos secundarios del medicamento que experimenta su estudiante?:

¿Su estudiante usa un medidor de flujo respiratorio máximo? _____

Si es así, ¿cuál es el mejor flujo respiratorio máximo actual del (de la) estudiante? _____

¿Su estudiante usa un espaciador para su inhalador? _____

Información / Instrucciones adicionales:

Firma del padre / tutor: _____ Fecha: _____

Teléf. de la escuela: 760-955-3201

Fax de la escuela: 760-257-1010

Plan de Acción para el Asma – Basado en Síntomas

Symptom Based – Asthma Action Plan

Nombre del Alumno: _____ FDN: _____ Escuela: _____

Padre/Tutor: _____ Teléf. de Casa: _____ Celular: _____

Lo siguiente debe ser completado por el MÉDICO: (Artículos #1, 2, 3, y 4):

1. Medicamento(s) (tomado en la escuela Y EN casa):

Por favor MARQUE la casilla si se requiere su uso en la escuela:

A. Nombre del medicamento de "RÁPIDO ALIVIO"	1. _____	<input type="checkbox"/> Para Escuela *
	2. _____	<input type="checkbox"/> Para Escuela *
B. Nombre del medicamento de "RUTINA" (ejem. Anti-inflamatorio)	1. _____	<input type="checkbox"/> Para Escuela *
	2. _____	<input type="checkbox"/> Para Escuela *
	3. _____	<input type="checkbox"/> Para Escuela *
C. Nombre de medicamento para ANTES DE Educ. Física, Esfuerzo:	1. _____	<input type="checkbox"/> Para Escuela *
	2. _____	<input type="checkbox"/> Para Escuela *

2. Para medicamentos inhalados por el alumno (todos los alumnos deben ir con la auxiliar de salud en la oficina para medicamento oral):

Auxiliar al alumno en la Oficina de Salud con medicamento inhalado *

Puede autosministrarse/cargar medicamento para inhalar. * El alumno muestra conocimiento. (No se recomienda en la escuela primaria).

3. Un Espaciador (spacer device) (ejem.: Aerochamber) se aconseja su uso por todos los alumnos en la escuela.

4. Revise los factores que provocan su asma: tabaco pesticidas animales pájaros cucarachas limpiadores humo de carro perfume veladoras humedad/moho polvo aire frío ejercicio smog polen otros

5. Utilizando los siguientes SÍNTOMAS, determine la ZONA apropiada y siga la acción indicada:

Zona Verde

Síntomas: Respira bien, no le falta la respiración por el día o la noche, no hay tos, no hay opresión de pecho, puede hacer ejercicios y sus actividades normales

Zona Amarilla

Síntomas: Comienza a toser, silbido, falta la respiración, opresión de pecho, se despierta por la noche debido a síntomas del asma, o tiene algunas restricciones de actividad

Acción para la escuela:

1. Dar medicamento(s) de "Rápido Alivio"
2. Avise al Padre si los síntomas NO mejoran con el medicamento después de 15 o 20 minutos
3. Si los síntomas NO MEJORAN siga el Plan de Emergencia de la Escuela abajo indicado
4. Si los síntomas mejoran, el alumno puede regresar a la clase
*Avise al padre si se ha utilizado el inhalador más de 2 veces en esta semana (si no es relacionado con actividad física)

Zona Roja

Síntomas: Tos, problemas para caminar o hablar, retracción de pecho/músculo del cuello al respirar, encorvado, color azul, silbido o sonidos disminuidos en la respiración, falta de respiración, restricción de actividad de moderada a severa, los síntomas permanecen igual o empeoran después de 30 minutos de estar en la Zona Amarilla

Acción para la escuela:

1. Dar medicamento(s) de "Rápido Alivio"
2. Si los síntomas no mejoran dentro de los siguientes 15 o 20 minutos con el medicamento de "Rápido Alivio" del alumno, o si los síntomas empeoran, siga el Plan de Emergencia de la Escuela abajo indicado

PLAN DE EMERGENCIA DE LA ESCUELA

1. REPITA el/los medicamento(s) de "Rápido Alivio" ahora
2. Llame al 911
3. Póngase en contacto con el padre/tutor y la enfermera de la escuela
4. REPITA el/los medicamento(s) de "Rápido Alivio" en 20 minutos si la ayuda no llega y los síntomas no han mejorado
5. Permanezca con el alumno hasta que lleguen los paramédicos

Nombre del Médico: _____ Firma del Médico: _____ Fecha: _____

Domicilio: _____ Teléfono: _____

Ciudad: _____ C.P.: _____

Doy mi consentimiento para que el personal de la escuela se comunique con el médico para consulta e intercambio de información según se requiera.

Firma del Padre o Tutor: _____ Fecha: _____ No. de Teléfono: _____

* Cualquier formulario de Autorización de Medicamento del Médico debe completarse junto con este Plan de Acción.

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: 760-955-3201 Ext. 10427 E-mail Address: jdieppa@vvuhsd.org

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

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

REVOCAION: 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: _____