Delphos City Schools

MEDICATION INFORMATION FORM

FOR THE ADMINISTRATION AND/OR SELF-POSSESSION OF ASTHMA INHALERS

Many students are receiving medication under a doctor's supervision. It is important that the school be aware of the effects the medication might have or is having on the school performance of the students. School personnel are occasionally requested to administer the medication. Under these circumstances, it is necessary that specific physician's recommendations be made available to the school.

A student may possess and use a metered dose inhaler or a dry powder inhaler to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms, if the following conditions are satisfied.

NAME OF STUDENT: _____ DATE OF BIRTH: _____

BLDG. _____ GRADE: _____ TEACHER : _____

STUDENT ADDRESS: _____

NAME OF INHALER MEDICATION: _____

RECOMMENDED DOSAGE/ROUTE: _____

MEDICATION TO START: _____ END DATE: (if known) _____

TIMES ADMINISTERED: _____

OTHER MEDICATIONS STUDENT IS TAKING: _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OR STORAGE OF MEDICATION: _____

_____

REACTIONS: The physician/pharmacologist is urged to list potential reactions the student might have to the medication:

_____

Procedure instructions for school personnel to follow if asthma medication does not produce expected relief from asthma attack: _____

_____

Other special instructions from the physician: _____

_____

During school hours, it is my understanding that the school secretary, principal, school nurse AND/OR the above stated child will administer the prescribed medication according to the specified physician's recommendation. The school nurse may contact this physician at any time for information about my child's condition or health care plan. I agree to submit a revised statement signed by the prescriber if any of the information provided on this form changes. This form is valid for the current school year only and will serve as a Medical Release Form between school and healthcare provider.

The above stated child has been instructed on proper use, storage, and administration of the prescribed inhaler and has demonstrated competency in self administration. ☐ ***Yes*** ☐ ***No***

Please check one : ☐ Inhaler may be kept with student or ☐ Inhaler must be kept in the office.

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

ASTHMA CARE PLAN

STUDENT NAME: _____ DATE OF BIRTH: _____

You have indicated that the above named student currently has **ASTHMA**. It is important to have at least annual health information when she/he needs help at school. Please complete this form so a plan can be established and shared with appropriate school personnel. It is the responsibility of the parent/guardian to provide necessary special food, medicine and treatment equipment needed at school. All students using an inhaler must follow district guidelines for medication use and are encouraged to use peak flow meters to determine their peak expiratory flow rate. If you have any questions, please call the school nurse. **REMEMBER TO NOTIFY SCHOOL IMMEDIATELY OF ANY CHANGES IN PHONE NUMBERS, CONTACT PERSONS, ETC.**

How often do asthma attacks occur? _____

Has the student been treated in the hospital for asthma in the past year? ☐ No ☐ Yes - When? _____

Is a peak flow meter used? ☐ No ☐ Yes - How often? _____ Best flow rate is: _____

Check any conditions that usually trigger an asthma episode:

☐ Respiratory infection

☐ Exposure to cold air

☐ Emotional stress

☐ Exercise – Describe: _____

☐ Odors – Describe: _____

☐ Allergic reactions to: _____

☐ Other _____

Check the signs that are usually present during an allergy attack:

☐ Coughing

☐ Wheezing

☐ Feels frightened

☐ Short of breath

☐ Bluish color of skin/nails

☐ Unable to speak sentence without taking a breath

☐ Other _____

Asthma Provider: _____ Phone: _____

Preferred Hospital: _____

Are medications needed to control asthma? List below the medications needed.

Medication	Amount taken	Time of Day	Taken at school [1]

The usual procedure followed at school for asthma is:

1. **Allow the student to use prescribed asthma medication with assistance given as needed. [1]**
2. **Encourage relaxation with slow deep breathing, sipping warm fluids.**
3. **Stay with the student and monitor for symptoms.**
   a. **If symptoms decrease after 15 minutes, return to class.**
   b. **If symptoms remain the same after 15 minutes, the parent will be contacted for directions.**
   c. **If symptoms increase in severity, school will call 911, CPR will be started if needed, parents called.**

Please indicate any additional information[2] _____

_____

[1]The district medication policy requires parental and physician signature on district forms for all medications administered during school activities.
[2]Any treatments or test and activity restrictions require written directions from the student's physician or primary care provider.

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____