

AUTHORIZATION FOR ASTHMA CARE AT SCHOOL

Student Name: _____ Teacher: _____

Medications that have been prescribed for use at school may be administered by a school nurse or authorized staff member If:
1) the medication has been appropriately labeled by a pharmacist under the direction of a licensed health care provider
2) the parent or legal guardian has granted permission below for the specific medication to be administered at school
(Please note that medication that have been duly prescribed for self-administration by a school age minor child require completion of an "Asthma Medication Self-Administration Form" as set forth by the Missouri Safe School Act of 1996).

Medication Name _____ Dose _____ Time/Interval _____
Route/ inhalation device _____ Instructions _____

Medication Name _____ Dose _____ Time/Interval _____
Route/ inhalation device _____ Instructions _____

Medication Name _____ Dose _____ Time/Interval _____
Route/ inhalation device _____ Instructions _____

+++++
Allergies: list known allergies to medications, food, or air-borne substances _____

*Has the child been hospitalized for asthma-related problems in the last three years? ____ If so, when? _____

*Has this child required urgent or emergency care due to asthma in the last three years? ____ If so, when? _____

Has the child been instructed to take a medication daily to control asthma? ____ If so, when? _____

If the answer to these questions is yes, please call _____ to schedule a time to meet with the school nurse. A history and needs assessment form should be completed. An asthma action plan should also be on record with the school.

I, the parent or legal guardian of the student listed above, give permission for administration of the above listed medications. I, also grant permission for exchange of information with the health care provider to facilitate my child's asthma and allergy Care.

Parent/Guardian Name _____ Phone (H) _____
Address _____ Phone (W) _____ Cell _____

Parent/Guardian Name _____ Phone (H) _____
Address _____ Phone (W) _____ Cell _____

Emergency Phone Contact #1 _____
Name relationship phone
Emergency Phone Contact #2 _____
Name relationship phone

Physician student sees for Asthma _____ Phone _____

Other Physician _____ Phone _____

Signature of parent/legal guardian _____ Date _____

STUDENT ASTHMA ACTION CARD

Name _____ Grade ____ Age ____

Teacher _____ Room _____

Parent/Guardian Name _____ Phone (H) _____

ID Photo

Address _____ Phone (W) _____

Parent/Guardian Name _____ Phone (H) _____

Address _____ Phone (W) _____

Emergency Phone Contact #1 _____

Name Relationship Phone

Emergency Phone Contact #2 _____

Name Relationship Phone

Physician student sees for Asthma _____ Phone _____

Other Physician _____ Phone _____

DAILY ASTHMA MANAGEMENT PLAN

- Identify the things which start an asthma episode (Check each that applies to student)

_____ Exercise	_____ Strong odors or fumes	_____ Other:
_____ Respiratory infections	_____ Chalk dust	_____
_____ Change in temperature	_____ Carpets in the room	_____
_____ Food _____	_____ Pollens	_____
	_____ Molds	

- Control of School Environment
(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode)

- Peak Flow Monitoring
 Personal Best Peak Flow number _____
 Monitoring Times _____

- Daily Medication Plan

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____
_____ or has a peak flow reading of _____.

• **Steps to take during an asthma episode:**

1. Give medication as listed below. _____
2. Have student return to classroom if _____
3. Contact parent if _____
4. Seek emergency medical care if the student has any of the following:

- √ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
- √ Peak flow of _____
- √ Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Child is hunched over
 - Child is struggling to breathe
- √ Trouble walking or talking
- √ Stops playing and can't start activity again
- √ Lips or fingernails are gray or blue

**If This Happens, Get
Emergency Help Now!**

• **Emergency Asthma Medications:**

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments/Special Instructions:

Parent Signature

Date

Signature of School Nurse

Date