

Authorization for Asthma Care at School

(date)

Dear _____

According to school health information, your child _____ has been identified as having a history of asthma. In attempting to better meet your child's needs at school, I ask that you complete the enclosed form. This form enables school health personnel to administer needed medication to your child at school, as determined by your child's health care provider. It also enables the appropriate treatment of your child's asthma during an emergency situation.

If no medications are needed at school, you may skip to the middle of the next page and complete only the lower half of the page, beginning with the section for allergies. Please be certain to answer the three questions indicated with an asterisk (*), as this will help us to determine the severity of your child's asthma.

Please sign and return the form to school with your child. If medications are needed at school and/or if you have answered yes to any of the questions preceded by an asterisk, please call me at 636-532-1151 ext 327 to discuss your child's asthma care further. I look forward to working with you and your child.

Sincerely,

Cavele Albertelli, RN

school nurse

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 medications 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 Schools Act of 1996).

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

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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 any of 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: _____ Home Phone: _____

Address: _____ Work Phone: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Emergency Contacts:

Name: _____ Phone: _____

Health Care Provider: Name: _____ Phone: _____

Address: _____ Fax: _____

Signature of parent/legal guardian _____ Date _____

School Asthma Action Plan

Student Name _____ Teacher/Team _____

1. Triggers that might start an asthma episode for this student:

- Exercise
 Animal Dander
 Cigarette smoke, strong odors
 Respiratory Infections
 Pollens
 Temperature Changes
 Foods _____
 Emotions (e.g. when upset)
 Molds
 Irritants (e.g. chalk dust)
 Other _____

2. Control of the School Environment:

_____ Environmental measures to control triggers at school _____
 _____ Pre-Medications (prior to exercise, choir, band, etc.) _____
 _____ Dietary Restrictions _____

3. Peak Flow Monitoring

_____ Monitor Peak Flow:
 Personal Best Peak Flow _____ Monitoring Times _____
 _____ Do Not Monitor Peak Flow

4. Routine Asthma and Allergy Medication Schedule

| Medication Name | Dose/Frequency | When to Administer | |
|-----------------|----------------|--------------------|-----------|
| | | At Home | At School |
| | | | |
| | | | |
| | | | |

5. Field Trips: Asthma Medications and supplies must accompany student on all field trips. Staff member must be instructed on correct use of the asthma medications and bring a copy of the Asthma Action Plan and Contact Phone Numbers.

1. Parent to Contact _____
 Phone Number(s) _____
 2. Other Person to Contact in Emergency _____
 Phone Number(s) _____

Parent/Legal Guardian Signature _____ Date _____

Reviewed by the School Nurse _____ Date _____

School Asthma Quick Relief & Emergency Plan

****Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

| | | | |
|-----------------|--------------------------|--------------------------------|------------------------------------|
| Severe cough | Shortness of Breath | Sucking in of the chest wall | Difficulty walking from breathing |
| Chest tightness | Turning blue | Shallow, rapid breathing | Difficulty talking from breathing |
| Wheezing | Rapid, labored breathing | Blueness of fingernails & lips | Decreased or loss of consciousness |

Steps to Take During an Asthma Episode:

1. Give Emergency Asthma Medications As Listed Below:

| Quick Relief Medications | Dose/Frequency | When to Administer |
|--------------------------|----------------|--------------------|
| 1. | | |
| 2. | | |

2. Contact Parents if _____

3. Call _____ to activate EMS if the student has ANY of the following:

- Lips or fingernails are blue or gray
Student is too short of breath to walk, talk, or eat normally
- No relief from medication within 15-20 minutes with any of the following signs
 - Chest and neck pulling in with breathing
 - Child is hunching over
 - Child is struggling to breathe

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school Nurse to communicate with the primary care provider/specialist about asthma/allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Legal Guardian Signature _____ Date _____
 Reviewed by School Nurse _____ Date _____

Parental Consent for Medication Administration to the Child

Date: _____ School: _____

Student: _____ Grade: _____

My child is to receive _____ medication according to the physician's directions given for _____

This treatment will last _____

My child has _____ drug allergies.

I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.

I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.

Signature: _____

Physician Consent for Medication Administration

Date: _____ Name of Student: _____

Medication: _____ Dose: _____

Time Interval: _____

Diagnosis or reason for treatment: _____

Side Effects to look for: _____

Restrictions: _____

Signature: _____