

Asthma Medication Permission Form

Student's Name _____ Date of Birth _____ Age _____
 School _____ Grade _____ Teacher _____
 Address/City/Zip _____
 Mother/Guardian Name _____ Work/Cell Number _____
 Address/City/Zip _____ Home Number _____
 Father /Guardian Name _____ Work/Cell Number _____
 Address/City/Zip and phone number, if different from above _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Physician's Name _____
 Address _____
 Phone Number _____ Emergency Number _____
 Medication _____
 Symptoms which this medication is to be given _____
 Dose _____
 Frequency _____
 Maximum # of doses @ school _____
 Peak flow readings _____
 Beginning date _____ Ending date _____

Permission for the Self-Administration and Carrying the Asthma Medication by the Student

This child is capable of self-administration of this medication while on school property or school-related events or activities. This means the prescription medication may be used at the student's discretion. Yes ___ No ___

The student may carry the medication. Yes ___ No ___

Physician Signature _____ Date _____

Parent/Guardian

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston - Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston - Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/Guardian Signature _____ Date _____

Reference: Asthma and Allergy Foundation of American, 1233 20th St, NW Suite 402, Washington, DC 20036 * www.aafa.org* 1-800-ASTHMA

Individualized Health Care Plan for Asthma

What Starts an Asthma Episode? (Check each that applies to the student.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Respiratory infection |
| <input type="checkbox"/> Changes in temperature | <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Carpet in the room |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Foods _____ | | |
| <input type="checkbox"/> Other(s) _____ | | |

Control of School Environment

List any environmental control measures, dietary restriction, or other items that the student needs to prevent an asthma episode.

Peak Flow

Normal level is _____

What conditions to use on PRN bases? _____

What to do for peak flow readings of different levels _____

Emergency Plan

Emergency Action is necessary when the student has symptoms such as _____

Peak flow reading is _____

Steps to Take during an Asthma Episode (check appropriate steps that apply)

- Check peak flow.
- Give medications as listed above. (Student should respond to treatment in 15-20 minutes.)
- Contact parents/guardians if _____
- Re-check peak flow.
- Seek emergency medical care (911) if the student has any of the following:
 - Coughs constantly.
 - 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
 - ◆ Stooped body posture
 - ◆ Struggling or gasping
- Trouble walking or talking.
- Stops playing and can't start activity again.
- Lips or fingernails are gray or blue.

Special instructions _____

This "IHCP" may be give to teachers, substitute teacher, and staff.

School Nurse/Representative _____ Principal _____

Teacher _____ Parent _____ Student _____

As appropriate: Coach _____ Extended Day Coordinator _____

Physician: _____

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SCHOOL ASTHMA ACTION PLAN
(Please print legibly)

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's name: _____ Grade: _____ DOB: _____

Teachers' Name: _____ School Year: _____

Parent/Guardian: _____ Home phone: _____

Address: _____ Work phone: _____

Emergency Contact: _____ / Relationship: _____

Phone Number (s): _____

Physician student sees for asthma: _____ Phone: _____

Other physician: _____ Phone: _____

Daily Treatment Plan

Please list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions

Name	Purpose	Dosage	When to use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

These medications are prescribe for the time period _____ until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

ASTHMA ACTION PLAN, p. 2

EMERGENCY PLAN

Emergency Action is necessary when this student has symptoms such as:

- 1. _____ 2. _____
- 3. _____ 4. _____

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick - relief medication)

Name: _____

Purpose: _____

Dosage: _____ When to use: _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart

Oxygen saturation with pulse oximeter (if available): Norms expected for student _____ % to _____ %

Call 911 or EMS if minimal or no improvement

B. Other medications:

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Oxygen saturation is at or below _____ %.
- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips of fingernails turn gray or blue

Comments and special instructions: _____

Physician's Signature (stamp not accepted) _____ Date _____

Parent/Guardian's Signature _____ Date _____