

AUTHORIZATION FOR ASTHMA CARE AT SCHOOL

STUDENT NAME _____ **Date of Birth** _____

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 properly labeled by a pharmacist under the direction of a licensed health care provider, 2) the parent or legal guardian has granted permission for the specific medication to be administered at school.

MEDICATION INFORMATION

Medication Name _____ **Dose** _____ **Time/Interval** _____

Route/Inhalation Device _____ **Instructions** _____

Medication Name _____ **Dose** _____ **Time/Interval** _____

Route/Inhalation Device _____ **Instructions** _____

List known allergies to medications, food, or air-borne substances. _____

How long has your child had asthma? _____

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

How many days of school did your child miss last year due to asthma? _____

Describe any special care your child requires at school. _____

PARENT/GUARDIAN CONTACT INFORMATION

Name _____ Home phone _____

Address _____ Work phone _____

Name _____ Home phone _____

Address _____ Work phone _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

HEALTH CARE PROVIDER CONTACT INFORMATION

Name _____ Phone _____

The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer life-saving medications when the following criteria are met:

- 1) *Written authorization by the parent/guardian*
- 2) *Medical history of student's asthma on file at the school*
- 3) *Written asthma action plan/individual healthcare plan on file at school*
- 4) *Written authorization from the prescribing health care provider that child has asthma, has been trained in the use of the medication and is capable of self-administration of the medication.*

**** Self-Carry applicable to Middle School/High School Students ONLY, unless deemed necessary by physician. ****

I, the parent or legal guardian of the student listed above, give permission for administration of the above listed medications. I also give permission for this child to carry and self-administer the above medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms for 3 or more hours. My signature below also grants permission for exchange of information with the health care provider to facilitate my child's asthma and allergy care.

Signature of Parent/Legal Guardian _____ **Date** _____

I, a licensed health care provider, certify that this child has a medical history of asthma, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms for at least 3 hours.

Signature of Health Care Provider _____ **Date** _____

Address _____ **Phone** _____

SCHOOL ASTHMA ACTION AND EMERGENCY RELIEF PLAN

STUDENT NAME _____ Date of Birth _____

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

- Exercise Animal Dander Cigarette smoke, strong odors Respiratory Infections
- Pollens Temperature Changes Irritants (e.g. chalk dust) Emotions (e.g. when upset)
- Molds Foods _____ 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 asthma medications and bring a copy of Asthma Action Plan.

Parent to Contact _____

Phone Number _____

Other Emergency contact _____

Phone Number _____

****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.**

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

STEPS TO TAKE DURING AN ASTHMA EPISODE

1. Give Emergency Asthma Medications
2. Contact parents
3. Call 911 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 medications 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 or designee 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/designee to communicate with the primary care provider 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/Designee _____ Date _____