May 1, 2013

Dear Parent/Guardian,

Your child's health record lists asthma as a health concern for your child. Please help your child's school to better understand the severity of your child's asthma by completing the attached **Asthma History Form** and returning it to the health room at school.

All medications to be given during the school day or school sponsored event require a current health care provider's order and parent permission form completed at the beginning of each school year. If your child's asthma requires them to have an inhaler or nebulizer at school, please have the health care provider complete the top portion of the enclosed **Health Care Provider Medication Request and Treatment Plan for Asthma form.** You will need to complete the bottom half and bring the form and the medication to the school. Medications must have a current pharmacy label matching the orders written by the health care provider. The **Authorization for Exchange of Medical Information Form** can be filled out and signed by you and returned to your child's school nurse.

Please contact your child's school if you have any questions.

Sincerely,

Health Services
Clover Park School District.

Pierce County Medical Society

HEALTH CARE PROVIDER MEDICATION REQUEST AND TREATMENT PLAN FOR ASTHMA

School Year	School	Fax

Student Name: ______________________________ has asthma and may need to take medication at school.

The treatment plan for managing asthma at school is as follows: (check all that apply)

☐ Administer rescue medication if student experiences symptoms (coughing, difficulty breathing, wheezing, chest tightness):

Drug and Dosage Form	Dose, Time, and Mode of Administration
☐ Albuterol Inhaler ☐ with spacer	☐ 2 (or _______) puffs by mouth 5-20 minutes prior to exercise. ☐ 2 (or _______) puffs by mouth every 3-4 hours as needed for symptoms. ☐ If no relief after treatment, **call 911**. ☐ Other:
☐ Albuterol via Nebulizer ☐ Levalbuterol via Nebulizer ☐ mouthpiece ☐ mask	☐ 1 unit dose every ________ hours as needed for symptoms. ☐ Other:
☐ Other:	

☐ Use peak flow meter per attached directions.

☐ Student is to inform school nurse if using albuterol inhaler more than 4 times/day or if asthma causes awakening at night.

☐ Other: ____

☐ Student has been instructed in use of device needed to administer medication.

☐ Student has demonstrated the skill level necessary to use the medication appropriately.

☐ Student recognizes symptoms of asthma and will seek assistance if needed.

☐ Student may carry and self-administer the medication ordered above.

______________________________ ______________ ______________
Health Care Provider's Signature Telephone Fax

______________________________ ______________
Health Care Provider's Printed Name or Stamp Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, (name of child) ______________________________, or allow my child to carry and self-administer as indicated above, the medication prescribed by (name of health care provider) ______________________________ for the school year ending June ____________. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, <u>I will collect the medication from the school or understand that it will be destroyed</u>. I am the parent or the legal guardian of the child named.

____
Parent/Guardian Signature

Phone Contacts	
Work:	Cell:
Home:	Other:

____
Date

<u>Thank you for your assistance. Please return completed form to school nurse.</u>

Student demonstrates skill level necessary to self-administer medication as ordered above.	
School Nurse Signature:	Date:

ASTHMA HISTORY FORM (Page 1 of 2)

Student's Name: ______________________ Date of Birth: __________

History taken by: ______________________ Date: ______________

Parent/guardian name: ______________________________

Home phone: __(____)__________ Work phone: __(____)__________

Alternate contact: ______________________ Phone: ___(____)________

Primary Health Care Provider: ______________________ Phone: ___(____)________

Address: ____

When was this student's asthma first diagnosed: ______________________

How many times has this student been seen in the emergency room for asthma in the past year? __________

How many times has this student been hospitalized for asthma in the past year? __________

Has this student ever been admitted to an intensive care unit for asthma? ______
When? __________

How would you rate the severity of this student's asthma?

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate this student missed last year because of asthma? __________

What triggers this student's asthma:

- ☐ exercise
- ☐ respiratory infection
- ☐ strong odors or fumes
- ☐ stress
- ☐ cigarette smoke
- ☐ wood smoke
- ☐ pollen
- ☐ animals (specify): ______________________
- ☐ foods (specify): ______________________
- ☐ carpets
- ☐ indoor dust
- ☐ outdoor dust
- ☐ chalk dust
- ☐ temperature changes
- ☐ molds
- ☐ other: ______________________

What does this student do at home to relieve asthma symptoms (check all that apply):

- ☐ breathing exercises
- ☐ rest/relaxation
- ☐ drinks liquids
- ☐ takes medications (see below)
- ☐ uses herbal remedies (see below)
- ☐ other (please describe) ______________________

ASTHMA HISTORY FORM (Page 1 of 2)

What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc)	How Often
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

What herbal remedies, if any, does this student take for asthma? ____________________

____

Does this student use any of the following aids for managing asthma?

- ☐ peak flow meter (personal best if known ____________)
- ☐ holding chamber ☐ spacer ☐ holding chamber w/mask
- ☐ other: ______________________________

Please check special needs related to your child's asthma:

- ☐ physical education class ☐ recess ☐ animals in classroom
- ☐ avoidance of certain foods ☐ field trips ☐ access to water
- ☐ transportation to and from school
- ☐ observation of side effects from medications ☐ other

If you checked any of the above boxes, please describe needs:

____

____

Has this student had asthma education? ☐ yes ☐ no
Would you like information about asthma education for ☐ student ☐ self

Parent Signature: ______________________________ Date: ____________

Nurse Signature: ______________________________ Date: ____________