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 when 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.)

- ☐ Exercise
- ☐ Changes in temperature
- ☐ Animals
- ☐ Foods_____
- ☐ Other(s)_____
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Pollens
- ☐ Respiratory infection
- ☐ Carpet in the room
- ☐ Molds

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 given to teachers, substitute teacher, and staff.

School Nurse/Representative _____Principal _____

Teacher _____Parent_____ Student_____

As appropriate: Coach _____Before/After Program Coordinator_____

Physician: _____

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Individualized Health Care Plan to Carry or Self-Administer Asthma Medication by a Student

To be completed by the student:

I, _____ have asthma. I may take the medication _____.
The following symptoms indicate that I need to take the medication: _____
_____

- When I take my medication I will take _____ puffs.
- I will take it only _____ hours apart or at the times of _____.
- If there is not an improvement, I will see the school nurse, school representative, or adult who is caring for me immediately.
- I will inform the adult caring for me when I take the medication. I will inform the school nurse or school representative _____ (when) the medication is taken and document the taking of the medication. If I am at a school event or activity after school, I will inform the school nurse or school representative early the next day to document the use of the medication.
- I will never share my inhaler with anyone else.
- I will store my medication _____ while in school. While at a school-related event or activity, I will store it _____. I know a spare_____ _____ is at School. I know there is a spare _____ when away from school.
- I will meet with the school nurse or the school representative every _____ to check on the use of my medication.
- I understand that my teachers, school nurse or school representative, and others will be monitoring my use of the medication. If there is cause the privilege will be limited or revoked.

Student Signature _____ Date: _____

To be completed by school nurse or school representative

The school nurse is _____. If there is not a school nurse then the person designated by the principal to administer medication is _____.

_____ The student has demonstrated the proper use of the inhaler.
_____ The student is capable of using the inhaler as stated.
_____ All appropriate adults will receive an in-service.

Parent _____

School Nurse/Representative _____

Principal _____

Teacher _____

As appropriate: Coach _____

Before/After Program Coordinator_____

Student _____ Date _____

Physician _____ **Date** _____

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