

# ASTHMA

To: Parent(s)/Guardian of: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

You have checked on school records that this student currently has **asthma**. It is important to have at least annual health information when s/he needs help at school. Please complete this form and return it to the school nurse so a plan to help your child can be shared with identified school personnel. It is the responsibility of parents to provide necessary special food and medicine needed at school. If you have questions, you may call the nurse at the student's school.

How often do asthma symptoms occur? \_\_\_\_\_

Has student been treated in the hospital for asthma in the past year?  No  Yes (When? \_\_\_\_\_)

Check the conditions that usually bring on this student's asthma symptoms:

- Respiratory infection
- Exercise (describe, e.g., after running) \_\_\_\_\_
- Odors (describe) \_\_\_\_\_
- Allergic reaction to (describe: e.g., peanuts, carpets, etc) \_\_\_\_\_
- Other (describe) \_\_\_\_\_

Check the symptoms that occur:

- Coughing
- Wheezing
- Shortness of breath
- Other (describe) \_\_\_\_\_
- Feeling frightened
- Bluish color of skin/nails
- Unable to speak sentence w/o taking a breath

Asthma is currently being treated by Dr: \_\_\_\_\_ Phone: \_\_\_\_\_

Are medications\* needed at school?  No  Yes (Please list below)

	Medication*	Amount to take	When to take
1.			
2.			
3.			

\* Parents are responsible for sending necessary medications to school

\* If 'rescue' inhalers are prescribed, we recommend sending 2; 1 for the school office and 1 for the student to carry, if student is capable and responsible. Doctor's written permission is needed for students to carry and use their own inhalers.

**Please advise the school nurse immediately of changes in dose and/or type of medication.**

The usual procedure followed at school for a student's asthma is:

1. Allow student to use his/her prescribed asthma medication with assistance given, as needed.
2. Encourage student's relaxation (e.g., slow, deep breathing, sipping warm fluids, etc.).
3. Stay with student; monitor for symptoms.
  - a) If symptoms decrease within 15 minutes after taking medication, student may return to class.
  - b) If symptoms remain the same 15 minutes after taking medication, parent will be contacted for direction.
  - c) If symptoms increase in severity, 911 will be called and CPR begun, if necessary.

If you want additional help given, or have other concerns, describe here \* \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**Remember to advise the school immediately of changes in phone numbers, address, responsible emergency contact persons or doctor.**

\*Tests and activity restrictions require written direction from the student's doctor.

forms

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PHILOMATH SCHOOL DISTRICT 17J

Medication at School

\_\_\_\_\_  
(Student's Name)

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

How to be taken/administered: \_\_\_\_\_

Frequency of Administration: As needed for Asthma symptoms

Other Special Instructions: \*Call parent if no relief from symptoms

Inhaler is kept\*: (circle those that apply) in the school office / with the student

\* If a 'rescue' inhaler (eg. Albuterol) is prescribed, we recommend sending 2: 1 for the school office and 1 for the student to carry if the student is capable and responsible. Written permission from the doctor is required for students to carry and self-administer inhalers (see reverse).

I have read the Philomath School District 17J policy on administering noninjectable medicines to students. I hereby agree to hold the Philomath School District, its agents and employees, harmless for any and all liability known, or unknown, that may arise out of the use and/or taking of said medication.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date Medication Started

\_\_\_\_\_  
Date Medication Discontinued

\_\_\_\_\_  
Medication Released to:

Date	Time	Dosage	Initials

Date	Time	Dosage	Initials



**Permission to Carry Inhaler in Backpack or in Locker  
in Addition to Inhaler Kept in School Office**

\* We request two (2) inhalers (rescue inhaler medication only)  
1 in the office and 1 for student to carry

Date: \_\_\_\_\_

Student: \_\_\_\_\_

Grade: \_\_\_\_\_

My child is able to perform this procedure: (check all that apply)

\_\_\_\_\_ totally independent and with no assistance needed

\_\_\_\_\_ needs staff assistance

My child has been instructed in this procedure and is able to perform the procedure safely.  
He/she understands that all equipment and/or medication is for personal use only. I will notify  
the school if further supervision or other adjustments are necessary.

Parent signature \_\_\_\_\_

Date \_\_\_\_\_

Physician signature \_\_\_\_\_

Date \_\_\_\_\_

Physician name/ please print \_\_\_\_\_

Physician phone number \_\_\_\_\_