Parent Information Packet: Asthma Documentation Requested

To the parent of _____ Date: _____

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may have *Asthma.*

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special care and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

_____
School Health Staff

Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

____ This is no longer a health concern.
____ My child DOES have asthma:

- Prepare your child. Discuss the medication plan, appropriate use of inhalers and how to handle symptoms.
- Keep school staff up-to-date on any changes in your child's care.
- PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:
  - ☑ **Parent Asthma Questionnaire** form completed by parent/guardian
  - ☑ **Asthma Medical Management Plan for School** Form signed by an **Arizona Licensed Physician/Health Care Provider** and parent/guardian**:** If student requires an Albuterol Rescue Inhaler at school
  - ☑ **Please see school health staff if your child requires medications to be given at school.**

_____ _____ _____
Name of Parent and/or Guardian Signature Date

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Parent Asthma Questionnaire
To Be Completed By Parent

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

Emergency Contacts:
Name/Relationship Telephone Number(s)
1. _____ 1. _____ 2._____

2. _____ 1. _____ 2._____

Does your child currently take medication for asthma? □ Yes □ No

Your child's asthma is treated by (check all that apply)
□ Oral medication everyday
□ Medication when an asthma attack occurs
□ Nebulizer/inhaler treatments everyday
□ Nebulizer/inhaler treatments when an asthma attack occurs
□ My child's asthma has not required treatment since _____

Please list the medication(s) your child is currently taking _____

If these medications need to be provided at school, a *Consent to Administer Medications to Students Form* must be completed. You can obtain this form online or at the school health office.

Please check all triggers which may start an asthma episode for your child:
□ exercise □ respiratory infections □ cold air
□ animals □ plants/dust □ other_____

Please list your child's usual symptoms of an asthma attack.
_____

Please list any special instructions regarding field trips, recess, physical education classes.
_____

If your child uses a Peak Flow Meter, what is the personal best flow number? _____

If a Peak Flow Meter is to be used at school, please have the child's Arizona Licensed Physician/Health Care Provider provide treatment guidelines on the

Asthma Medical Treatment Plan for School *Form.*

_____ _____
Signature of Parent/Guardian Date

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Asthma Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by **Arizona Licensed Physician/Health Care Provider**

Student's Name:_____**D.O.B:**_____**Teacher:**_____

Steps to take during an asthma episode:
1. Check peak flow. (Please provide peak flow meter for school)
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____
4. Re-check peak flow.
5. **Seek emergency medical care if the student has any of the following:**

- ✓ Coughs constantly
- ✓ No improvement 16-20 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 of fingernails are grey or blue

EMERGENCY MEDICATIONS WITH DOSAGE AND INSTRUCTIONS:

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

Daily Asthma Management Plan

Identify the things which start an asthma episode (Check all that applies to the student.)

___ Exercise ___ Pollens ___ Strong Odors or Perfumes
___ Respiratory Infections ___ Chalk dust/dust ___ Molds
___ Change in temperature ___ Carpets in the room ___ Animals
___ Food ___ Other _____

Comments: _____

Control of School Environment
List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent and asthma episode:

_____

_____

_____

Peak Flow Monitoring
Personal Best Peak Flow Number: _____
Monitoring Times: _____

For rescue inhaler (Albuterol)
(Please Check One)

☐ I have instructed (student name) _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use his/her Albuterol Inhaler medication by him/herself and school. (Right to carry may be revoked if student found to be irresponsible with medication at school).

☐ It is my professional opinion that (student name) _____ SHOULD NOT carry his/her Albuterol Inhaler medication by him/herself at school.

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____

****Additional consent forms required for all medications to be administered during the school day