

# Asthma Packet

Please complete the following forms to better help us understand your child's health condition and provide a safe and healthy school environment.

- □ Authorization for Exchange of Information (Signature needed)
- □ Questionnaire (Signature needed)
- Authorization for Medication at School (Signature from parent and doctor needed)
- □ Medication Policy

If you have any questions or concerns please feel free to email any one of the Nurses below. We appreciate your help in providing the best care for your child.

> Sincerely, Alta Loma School District Nurses

Erin Stevens, MSN, RN estevens@alsd.org Karen Simon, MSN, RN ksimon@alsd.org Patti Boyle, BSN, RN pboyle@alsd.org



## PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION

To Whom It May Concern:

I hereby give my permission for the exchange of immunization/medical information contained in the record of my child:

Name of Student	Birthdate	Medical Record #(If applicable)
Between(Name of Physician	and	(School Nurse)
Address:	So	hool Stamp:
Physician Phone:	Fax	:
		diately and shall remain in effect until ne date of signature, if no date entered.
(enter date)		he date of signature, if no date entered.



## **ASTHMA ACTION PLAN**

How long has your chil	d had asthma?					
Rate the severity of his/ (not severe)	/her asthma. (Circle) 1 2 3 4 5 6 7 8		e)			
How many days would	you estimate he/she	e missed schoo	ol last year due to	asthma?		
How often does your ch What triggers your child		-	-	□Yearly		
□ Illness	□ Emotions		$\Box$ Medications			
□ Weather	□ Exercise		□ Chemical Od	ors		
□ Fatigue	$\Box$ Food		□ Other:			
What does your child d	o at home to relieve	e wheezing du	ring an asthma at	tack?		
□ Breathing Exercise	es [	🗆 Uses Inhale	r		□ Other:	
□Rest/relaxation	[	🗆 Uses Nebul	izer			
□ Drinks water Please list your child's Daily medication	medication(s).	□ Uses Oral N				
Medication(s) for	r asthma symptoms:					
Please list the medication Medication(s):						
					for asthma?	
How many times has yo	our child been hospi	italized in the	past year for asth	ma?		
How often does your ch	nild see a doctor for	routine evalu	ations?			
Do you know what you		eak flow rate i		No		
If your child suffers a s	evere asthma attack	at school, wh	at plan of action	would you p	prefer school personnel to take?	
Thank you for your tim		assessing you	r child's special r	eeds in scho	ool. By signing this form, you authors responsible for your child during t	
Parent Signature:				Date:		
Reviewed by R.N.:				Date:		



#### AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Exception: California Education Code 49423.5 specialized services, i.e., Epipen, nebulizer, glucagon, insulin, diabetes care, etc. may require additional forms and instructions signed by parents or legal guardian and physician. **This form is valid for** *only* **one school year**.

#### 1. Parent or Legal Guardian Section

**Note**: All medications must be prescribed, <u>including</u>, over the counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician.

I request that the designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse (or designee) to communicate with my child's prescriber and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees, harmless, for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I agree to comply with the district rules related to administering medication at school.

	$\Box M \Box F$						
Name of Child	Sex	Date of Birth					
Name of School	Grade						
I will <i>immediately</i> notify the school if there are any changes in medications my child is taking at school.							
Signature of Parent of Legal Guardian Date	Home Phone	e Work Phone					
		o receive the following prescribed medication during school hours.					
Name of medication (one medication per form)							
Dosage (Be specific, i.e., milligrams, etc.)							
Time of day to be given							
Frequency and Indication if "as needed"							
If "as needed" described indications and sequence of	orders						
Method of administration							
ORAL: □Liquid □Tablet □Inhaler							
DROPS: $\Box$ Eye _R _L $\Box$ Ear _R _L $\Box$ Nostril _R _L							
OTHER:   Topical  Other							
Precautions or side effects							
Additional special instructions							
Office Stamp		_					
Signature of Physician	Date						
Name of Physician (Please Print)	Office Telep	phone					



### **INFORMATION FOR PARENTS OF STUDENTS NEEDING TO TAKE MEDICATION AT SCHOOL**

Dear Parent/Guardian,

It is generally better to have medication administered at home; however, sometimes it is necessary for a child to take medication during school hours and we wish to assist you as needed. The school nurse serves several schools and is not available to help students take medication on a daily basis, so medically untrained, unlicensed school personnel most often perform this function. **Consequently we urge you, with the help of your healthcare provider, to work out a schedule to give medication outside school hours.** 

In compliance with California Education Code 49423, when an employee of the school district helps a student take medication, the employee must be acting in accordance with the written directions of a person licensed to prescribe medications and with the written permission of the child's parent or legal guardian. These authorizations must be renewed whenever the prescription changes and at the beginning of each school term. *THE INSTRUCTION LABEL ON PRESCRIPTION MEDICATIONS WHICH IS APPLIED BY THE PHARMACIST IS NOT ACCEPTABLE AS A PHYSICIAN'S STATEMENT. A PRESCRIPTION IS ALSO REQUIRED FOR OVER THE COUNTER MEDICATIONS. CHILDREN MAY TAKE MEDICATIONS AT SCHOOL ONLY WHEN A LEGAL PRESCRIPTION AND WRITTEN PARENT AUTHORIZATION ARE ON FILE. Prescriptions which are faxed to us must be followed by the original written prescription. Please ask your healthcare provider to mail the original at the time the fax is sent.* 

All medication must be stored in the health office. Children are not allowed to have medication in their possession at school, walking to and from school or on the school bus. This policy provides for the safety of all students on campus. The only exception to this policy is if the student's well-being is in jeopardy unless the medication, such as an inhaler for asthma, is carried on his/her person. The appropriate release forms can be obtained from the school and must include a statement from the physician that the student's well-being is in jeopardy unless he/she carries the medication.

Medication must be provided to the school in the container in which it was purchased, with the prescription label attached, and must be prescribed to the student who will take the medication. Students may not take medication brought to school in a plastic bag, plastic ware, or any other repackaging. Students may not take out of date medication at school. An adult must bring the medication to school along with the completed authorization form/s.

If you anticipate a visit to your child's physician or dentist and expect that medication may be prescribed or the dosage changed, please stop by the school office for the appropriate forms.

Thank you.

ALTA LOMA SCHOOL DISTRICT NURSES

Erin Stevens MSN, RN District School Nurse Karen Simon MSN, RN District School Nurse Patti Boyle, BSN, RN District School Nurse