SELA: THE INTERNATIONAL PRIVATE SCHOOL

Asthma Information Form for Parents/Guardians

*SELA: The International Private Schools' Policies and Guidelines on Asthma, Allergies and other Life-Threatening Conditions can be found in our Health Policies available on our website at suescuela.com by looking under about and then clicking on SELA's Health Policies.

1. Name: ____ DOB: ________________ Program or Grade: ________

2. Does your child have a diagnosis of asthma? Yes ____________ No ___________

3. Does your child have a diagnosis of reactive airway disease (RAD)? Yes ____________ No___________

4. Is your child followed by a pulmonologist? Yes____________ No_____________

5. If yes, name of MD _________________________ Date of Last Visit _______________Contact # _____________

6. Does your child take any daily, routine medication for their asthma or RAD? Yes__________ No _____________

7. Is your child prescribed a rescue inhaler? Yes ____________ No ____________

8. If yes, does your child use a spacer with their inhaler? Yes ___________ No ____________

9. Has your child ever had to be hospitalized due to their asthma or RAD symptoms? Yes _________ No _________

10. Please list any known triggers of your child's asthma or RAD symptoms:
____

Please provide a rescue inhaler and any required spacers needed for administration to the school **on or before the first day of school** with a new medication authorization form signed by the child's doctor and parent/guardian. <u>Rescue inhalers must be in the original prescription box with the child's name written on the prescription.</u>

The information above will help us to better understand your child's asthma and create a plan of care specific for your child. Please ensure the PCP or Pulmonologist completes and signs the **"Asthma Action Plan"** and **"Prescription Asthma Medication"** authorization form. Your signature is also required.

I give permission for the school nurse or director to:

--Discuss the health needs of my child with all pertinent school staff

--Contact the Primary Care Physician and/or Pulmonologist to discuss health concerns of my child if necessary.

Parent Signature: ____ Date: _________________

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Prescription Asthma Medication Authorization Form

The following section is to be completed by the ***Parent:***

Child's Name:________________________________ DOB: _________________ Program or Grade: ___________

Diagnosis: ____

Physician's Name: ________________________ Address: ____________________ Phone #: __________________

I give permission for the school nurse and/or director to share with appropriate school personnel information relative to the prescribed medication administration, as he/she determines necessary for my son/daughter's health and safety: ☐ Yes ☐ No Any restrictions on release:

____

I give permission for the school nurse and/or director to contact the Physician, PA or Nurse Practitioner listed below: ☐ Yes ☐ No

I request that my child be administered the medication described below as detailed on my child's asthma action plan by trained authorized personnel. ***(Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or by the end of the school year.)***

Parent/Guardian:___________________________________ ________________________________ ___________

Please print name *Signature* *Date*

The following section is to be completed by the ordering ***Physician, PA, or Nurse Practitioner:***

Diagnosis for which medication is ordered:	
Medication:	
Dosage:	
Route:	
List significant side effects/adverse reactions:	
How soon can it be repeated, if desired:	
Date to start:	**Date to stop:**
Any other medical condition(s):	
Other medication taken by the student:	
Other information:	

Physician, PA, Nurse Practitioner Signature: _______________________________________Date: ____________

American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone

Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): ____________________

____

Controller Medicine(s) Given in School: ____________________

Rescue Medicine: Albuterol/Levalbuterol ________ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol ________ puffs 15 minutes before activity as needed

😐 Yellow Zone

Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol ________ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: ____________________

☐ Add: ____________________

____

☐ Change: ____________________

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone

If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.

Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol ________ puffs every ________

Take: ____________________

____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

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