

Dear Parent,

Attached is the 2010-2011 asthma packet for you to complete and return to me for the upcoming school year. It is important that I have these on file by the first day of school, along with the inhalers needed in case of an asthma attack. Children in the 4<sup>th</sup> grade and above may carry their inhaler if you feel confident that they are able to administer the medication correctly. I still need to keep a file on these students. Please make sure that all asthma medications are in their original container labeled with the child's name and that the medication will not expired by the end of the year. All medications need a signed physician's order. Medication orders may be faxed to (636) 532-6502.

Should you have any questions please feel free to call the school office. If you miss place this packet it can be found on the bottom of my web page in the Favorite Links area.

Thank you,

Carol Albertelli, R.N.  
Ascension School Nurse

## *Authorization for Asthma Care at School*

\_\_\_\_\_  
(date)

Dear \_\_\_\_\_

According to school health information, your child \_\_\_\_\_ has been identified as having a history of asthma. In attempting to better meet your child's needs at school, I ask that you complete the enclosed form. This form enables school health personnel to administer needed medication to your child at school, as determined by your child's health care provider. It also enables the appropriate treatment of your child's asthma during an emergency situation.

If no medications are needed at school, you may skip to the middle of the next page and complete only the lower half of the page, beginning with the section for allergies. Please be certain to answer the three questions indicated with an asterisk (\*), as this will help us to determine the severity of your child's asthma.

Please sign and return the form to school with your child. If medications are needed at school and/or if you have answered yes to any of the questions preceded by an asterisk, please call me at 636-532-1151 ext 327 to discuss your child's asthma care further. I look forward to working with you and your child.

Sincerely,

*Cavele Albertelli, RN*

\_\_\_\_\_  
school nurse

# AUTHORIZATION FOR ASTHMA CARE AT SCHOOL

Student Name: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medications that have been prescribed for use at school may be administered by a school nurse or authorized staff member if: 1) the medication has been appropriately labeled by a pharmacist under the direction of a licensed health care provider  
2) the parent or legal guardian has granted permission below for the specific medication to be administered at school  
(Please note that medications that have been duly prescribed for self-administration by a school-age minor child require completion of an "Asthma Medication Self-Administration Form" as set forth by the Missouri Safe Schools Act of 1996).

Medication Name \_\_\_\_\_ Dose \_\_\_\_\_ Time/Interval \_\_\_\_\_  
Route/inhalation device \_\_\_\_\_ Instructions \_\_\_\_\_

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Route/inhalation device \_\_\_\_\_ Instructions \_\_\_\_\_

Allergies: list known allergies to medications, food, or air-borne substances \_\_\_\_\_

\*Has the child been hospitalized for asthma-related problems in the last three years? \_\_\_\_\_ If so, when? \_\_\_\_\_

\*Has this child required urgent or emergency care due to asthma in the last three years? \_\_\_\_\_ If so, when? \_\_\_\_\_

\*Has the child been instructed to take a medication daily to control asthma? \_\_\_\_\_ If so, when? \_\_\_\_\_

\*If the answer to any of these questions is yes, please call \_\_\_\_\_ to schedule a time to meet with the school nurse. A history and needs assessment form should be completed. An asthma action plan should also be on record with the school.

I, the parent or legal guardian of the student listed above, give permission for administration of the above listed medications. I also grant permission for exchange of information with the health care provider to facilitate my child's asthma and allergy care.

## Parent/Guardian:

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Emergency Contacts:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature of parent/legal guardian \_\_\_\_\_ Date \_\_\_\_\_

## *School Asthma Action Plan*

Student Name \_\_\_\_\_ Teacher/Team \_\_\_\_\_

### 1. Triggers that might start an asthma episode for this student:

- Exercise     
  Animal Dander     
  Cigarette smoke, strong odors     
  Respiratory Infections  
 Pollens     
  Temperature Changes     
  Foods \_\_\_\_\_     
  Emotions (e.g. when upset)  
 Molds     
  Irritants (e.g. chalk dust)     
  Other \_\_\_\_\_

### 2. Control of the School Environment:

\_\_\_\_\_ Environmental measures to control triggers at school \_\_\_\_\_  
 \_\_\_\_\_ Pre-Medications (prior to exercise, choir, band, etc.) \_\_\_\_\_  
 \_\_\_\_\_ Dietary Restrictions \_\_\_\_\_

### 3. Peak Flow Monitoring

\_\_\_\_\_ Monitor Peak Flow:  
     Personal Best Peak Flow \_\_\_\_\_ Monitoring Times \_\_\_\_\_  
 \_\_\_\_\_ Do Not Monitor Peak Flow

### 4. Routine Asthma and Allergy Medication Schedule

Medication Name	Dose/Frequency	When to Administer	
		At Home	At School

### 5. Field Trips: Asthma Medications and supplies must accompany student on all field trips.

**Staff member must be instructed on correct use of the asthma medications and bring a copy of the Asthma Action Plan and Contact Phone Numbers.**

1. Parent to Contact \_\_\_\_\_  
 Phone Number(s) \_\_\_\_\_
2. Other Person to Contact in Emergency \_\_\_\_\_  
 Phone Number(s) \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by the School Nurse \_\_\_\_\_ Date \_\_\_\_\_

# *School Asthma Quick Relief & Emergency Plan*

**\*\*Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

Severe cough	Shortness of Breath	Sucking in of the chest wall	Difficulty walking from breathing
Chest tightness	Turning blue	Shallow, rapid breathing	Difficulty talking from breathing
Wheezing	Rapid, labored breathing	Blueness of fingernails & lips	Decreased or loss of consciousness

## **Steps to Take During an Asthma Episode:**

### **1. Give Emergency Asthma Medications As Listed Below:**

Quick Relief Medications	Dose/Frequency	When to Administer
1.		
2.		

**2. Contact Parents if \_\_\_\_\_**

**3. Call \_\_\_\_\_ to activate EMS if the student has ANY of the following:**

- Lips or fingernails are blue or gray  
Student is too short of breath to walk, talk, or eat normally
- No relief from medication within 15-20 minutes with any of the following signs
  - Chest and neck pulling in with breathing
  - Child is hunching over
  - Child is struggling to breathe

### ***Parent Consent for Management of Asthma at School***

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school Nurse to communicate with the primary care provider/specialist about asthma/allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Reviewed by School Nurse \_\_\_\_\_ Date \_\_\_\_\_

## *Parental Consent for Medication Administration to the Child*

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

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

My child is to receive \_\_\_\_\_ medication according to the physician's directions given for \_\_\_\_\_

This treatment will last \_\_\_\_\_

My child has \_\_\_\_\_ drug allergies.

I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.

I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.

Signature: \_\_\_\_\_

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## *Physician Consent for Medication Administration*

Date: \_\_\_\_\_ Name of Student: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Time Interval: \_\_\_\_\_

Diagnosis or reason for treatment: \_\_\_\_\_

Side Effects to look for: \_\_\_\_\_

\_\_\_\_\_

Restrictions: \_\_\_\_\_

Signature: \_\_\_\_\_