

Asthma Medication Permission Form

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
 Address/City/Zip \_\_\_\_\_  
 Mother/Guardian Name \_\_\_\_\_ Work/Cell Number \_\_\_\_\_  
 Address/City/Zip \_\_\_\_\_ Home Number \_\_\_\_\_  
 Father /Guardian Name \_\_\_\_\_ Work/Cell Number \_\_\_\_\_  
 Address/City/Zip and phone number, if different from above \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER**

Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Emergency Number \_\_\_\_\_  
 Medication \_\_\_\_\_  
 Symptoms which this medication is to be given \_\_\_\_\_  
 Dose \_\_\_\_\_  
 Frequency \_\_\_\_\_  
 Maximum # of doses @ school \_\_\_\_\_  
 Peak flow readings \_\_\_\_\_  
 Beginning date \_\_\_\_\_ Ending date \_\_\_\_\_

Permission for the Self-Administration and Carrying the Asthma Medication by the Student

This child is capable of self-administration of this medication while on school property or school-related events or activities. This means the prescription medication may be used at the student's discretion. Yes \_\_\_ No \_\_\_

The student may carry the medication. Yes \_\_\_ No \_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

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

Reference: Asthma and Allergy Foundation of American. 1233 20<sup>th</sup> St, NW Suite 402, Washington. DC 20036 \* www.aafa.org\* 1-800-ASTHMA

**Individualized Health Care Plan for Asthma**

(July 2006)

What Starts an Asthma Episode? (Check each that applies to the student.)

- Exercise
- Strong odors or fumes
- Respiratory infection
- Changes in temperature
- Chalk dust
- Carpet in the room
- Animals
- Pollens
- Molds
- Foods \_\_\_\_\_
- Other(s) \_\_\_\_\_

**Control of School Environment**

List any environmental control measures, dietary restriction, or other items that the student needs to prevent an asthma episode.

\_\_\_\_\_

**Peak Flow**

Normal level is \_\_\_\_\_

What conditions to use on PRN bases? \_\_\_\_\_

What to do for peak flow readings of different levels \_\_\_\_\_

**Emergency Plan**

Emergency Action is necessary when the student has symptoms such as \_\_\_\_\_

\_\_\_\_\_

Peak flow reading is \_\_\_\_\_

**Steps to Take during an Asthma Episode (check appropriate steps that apply)**

- Check peak flow.
- Give medications as listed above. (Student should respond to treatment in 15-20 minutes.)
- Contact parents/guardians if \_\_\_\_\_
- Re-check peak flow.
- Seek emergency medical care (911) if the student has any of the following:
  - Coughs constantly.
  - No improvement 15-20 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 or fingernails are gray or blue.

**Special instructions** \_\_\_\_\_

(July 2006)

This "IHCP" may be give to teachers, substitute teacher, and staff.

School Nurse/Representative \_\_\_\_\_ Principal \_\_\_\_\_

Teacher \_\_\_\_\_ Parent \_\_\_\_\_ Student \_\_\_\_\_

As appropriate: Coach \_\_\_\_\_ Extended Day Coordinator \_\_\_\_\_

**Physician:** \_\_\_\_\_

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