

**USD #475**

**Secondary (Grades 6-12 only) Asthma Medication Permission Form**

MUST COMPLETE BOTH SIDES OF FORM WITH PHYSICIAN SIGNATURE REQUIRED

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ ID# \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Prescriber's Name \_\_\_\_\_

The above named student has been instructed in and understands the purpose and appropriate method and frequency of use of his/her asthma inhaler.

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\_\_\_\_\_ Student may carry and self-administer inhaler.

**Self-administration Authorization and Disclaimer:**

I grant permission for my child to carry and self-administer inhaled asthma medications as prescribed by the physician. I will have on file with the school nurse a physician completed and signed Student Asthma Action Form prior to my child being allowed to carry and self-administer inhaled asthma medications.

I also agree to release the USD 475 school district and all school personnel from any and all claims of liability - including but not limited to my child suffering any adverse reactions from self-carrying and self-administration of inhaled asthma medications.

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

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**OR**

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\_\_\_\_\_ Inhaler needs to be kept in the nurse's office and administered per physician orders.

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

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**For School Use Only**

**Contract Between Student and School Nurse for Student Self-Carry Inhaler**

1. Student has demonstrated to the nurse correct use of inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees to go to the nurse if after 2 puffs there is not marked improvement.
4. Student agrees to have the inhaler identified with his/her name on it.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

# STUDENT ASTHMA ACTION FORM – PHYSICIAN SIGNATURE REQUIRED

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Team: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_

Physician: \_\_\_\_\_ Ph: \_\_\_\_\_

Asthma Severity (Required):  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

Asthma Symptom Triggers (Required):  Exercise  Dust  Pollen/mold  Respiratory Infections

Animals  Temperature Change  Strong odors/fumes  Other \_\_\_\_\_

## **EMERGENCY PLAN**

Take Emergency Action for the following symptoms: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, O<sub>2</sub> Sat of \_\_\_\_\_, or a peak flow of \_\_\_\_\_.

### • Steps to take during an asthma episode:

1. Check O<sub>2</sub> Sat and/or peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if: \_\_\_\_\_

4. Re-check O<sub>2</sub> Sat and/or peak flow.

5. SEEK EMERGENCY MEDICAL care if the student has any of the following:

- ✓ Coughs constantly
- ✓ No improvement 15-20 minutes after initial treatment
- ✓ O<sub>2</sub> Sat of \_\_\_\_\_ and/or peak flow of \_\_\_\_\_
- ✓ Difficulty breathing accompanied by:
  - 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 grey or blue



**IF THIS  
HAPPENS, GET  
EMERGENCY HELP  
NOW!**

### • Emergency Asthma Medications (Check all that apply):

Name	Amount	When to Use
1. <input type="checkbox"/> Albuterol Inhaler	2 sprays	15 minutes prior to exercise
2. <input type="checkbox"/> Albuterol Inhaler	2 sprays	very 4 hours prn wheezing, coughing, shortness of breath
3. <input type="checkbox"/> _____		
4. <input type="checkbox"/> _____		

### • Inhaled Asthma Medications (Check one):

- I have instructed the above named student in the proper administration of his/her medications. It is my professional opinion that he/she should be allowed to self-administer the inhaled medication checked above.
- It is my professional opinion that the above named student should not self-administer his/her medication.

\_\_\_\_\_  
Required Physician Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

