ASTHMA CARE AT SCHOOL

(date sent)

(home address)

Dear _____:

According to school health information, your child _____ has been identified as having a history of asthma. To better meet your child's needs at school, please complete and return the enclosed form by _____ (insert date). 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. Please be certain to answer the six questions indicated with an asterisk (*), as this will help us to determine the seriousness 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 _____ to discuss your child's asthma care further. I look forward to working with you and your child.

Sincerely,

_____
school nurse

_____
school nurse e-mail address

_____
school nurse contact number

_____
school nurse fax number

ASTHMA CARE AT SCHOOL

Student Name:_____ Teacher:_____

*Medications that have been prescribed for use at school and at home 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 _____

_____

Medication Name_____ Dose_____ Time/Interval_____

Route/inhalation device _____ Instructions _____

_____

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

_____

* How many times in the last 3 years has your child required urgent or emergency care due to asthma? _____ When? _____
* How many times in the last 3 years has your child been hospitalized due to asthma-related problems? _____ When?_____
* Has your child been instructed to take a medication daily to control asthma? _____ If so, when? _____
* Has your child recently been waking up at night coughing? _____ If so, how many nights a month? _____
* Has your child recently been coughing and draining a lot of daytime mucous? _____ If so, how often? _____
* Has your child had asthma symptoms that are worse in certain seasons? _____ If so, what seasons? _____

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: _____

Cell Phone: _____ E-mail Address: _____

Name:_____ Home Phone:_____

Address:_____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Emergency Contacts:

Name:_____ Phone:_____

Student's Health Care Provider:

Name: _____ Phone:_____

Address:_____ Fax:_____

Signature of parent/legal guardian_____ Date_____