Parent/Guardian Asthma Letter

Pierce City Schools

Dear Parents or Guardian of: _____

Grade: _____

Date: _____

You are receiving this letter because you indicated on the health history form that your child has asthma. In order for us to provide the best care for your child, we need your help with the following:

Please check one of the following:

_____ My child no longer has asthma symptoms and receives no treatment or medication.

_____ My child still has asthma symptoms but does not receive treatment or medication.

_____ My child still has asthma symptoms and receives treatment and medication at

_____home _____school

If you marked the last choice, we ask that you complete the attached forms and return them to the school nurse as soon as possible:

- **Parent/Guardian Asthma Information form**- This gives us important health information related to the student's asthma and authorization to discuss asthma treatment with the student's doctor, if indicated.
- **Medication Authorization Request form** - This gives the health team and school permission to give asthma medication to your child.
- **Asthma Action Plan is required from your Physician.**
- **Permission to Carry Inhaler form -** Agreement from Parent/Guardian and student to carry inhaler at school. **(Note: signed authorization from the physician is required** (can be included in the Asthma Action Plan)**).**

Should you have any questions or concerns, please feel free to call at

(417) 476-2515 ext. 2100 (Elementary) or ext. 3100 (Middle & High School).

Thank you,

Sarah Elbert, RN

Kristi Barchak, RN

Pierce City R-VI
School Nurses

Pierce City Schools

Asthma Information - Parent/Guardian Form

Student's Name_____ DOB_____ Grade_____ Bus #_____

Parent/Guardian_____Phone_____Work #_____

Parent/Guardian_____Phone_____Work #_____

Emergency Contact _____Relationship_____Phone_____

Physician/Clinic _____ Office Phone_____

Does your child see another doctor/clinic for asthma? ____Y ____N If yes, please fill out Physician information below.

Physician/Clinic _____Office Phone_____

List all medications: School _____

Home_____

What triggers your child's asthma attack? Check all that apply.

- ☐ Insect Bites/ Stings
- ☐ Dust/ Dust mites
- ☐ Exercise
- ☐ Pest/ Roaches
- ☐ Cold air
- ☐ Strong odors, perfume, cleaning products
- ☐ Cigarette Smoke
- ☐ Stuffed Animals
- ☐ Mold
- ☐ Pets
- ☐ Weather changes
- ☐ Cold/ Flu/ Illness
- ☐ Carpet
- ☐ Ozone alert days
- ☐ Plants, flowers, pollen, cut grass
- ☐ Emotion

Does the student have an Epipen? _____Yes _____No

Describe the symptoms your child experiences before or during an asthma episode. Check all that apply.

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ "Tightness" in chest
- ☐ Breathing hard and fast
- ☐ Runny nose
- ☐ Rubbing chin/ neck
- ☐ Feeling tired/ weak
- ☐ Other _____

How long has your child had asthma? _____/years or _____/months

How often does your child wheeze or cough? _____/week or _____/month

Does your child have nighttime coughing or wheezing? _____Yes _____No If yes, how often? _____/week or _____/month

What does the student do at home to relieve breathing difficulties during an asthma attack?

☐ Rest/ relaxation ☐ Drinks/ liquids ☐ Medications ☐ Other: _____

Authorization for Release of Medical Information:

1. I **hereby authorize** _____ to furnish asthma—related information regarding my child
   Clinic/Provider

   _____to the Student Health Services personnel at Pierce City R-VI Schools.
   Student's Name

_____ _____ _____
Parent/Guardian Signature Print Name Date

2. **I give permission** for the school nurse to communicate with my child's doctor concerning their asthma and its treatment.

_____ _____ _____
Parent/Guardian Signature Print Name Date

Pierce City Schools

Parent/Guardian Authorization of Asthma Medication at School

Date: _____

Student Name: _____DOB: _____ Grade _____

Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.

Medication administration during school hours requires the following:

- Parent/Guardian written authorization for medication administration at school
- Asthma medication must be in it's original, labeled container. The label should include student's first and last name, name of medication, dosage and directions, and name of physician.
- Inhaler must NOT be expired.
- The first dose of this medication for the current condition/illness **may not be given at school.**

Please complete the following:

Med Name and Strength (only 1 med per page)	Dosage	Time(s) to be given at school	Type of Spacer	Medical condition for which medication is given	Medication expiration date	Additional comments

Medication Start Date: _____ Medication Stop Date: _____

Note: the first dose of any medication may NOT be given at school

Has the student ever received this medication before? Yes _____ No _____

1. I request that the above medication be given during school hours as ordered by the physician. I also request that the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication (dosage, time, ect).
4. I give permission for the school nurse to communicate, as needed, with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for trained school personnel to assist the student with their inhaler.

My Child _____ (circle one) **may / may not** carry the inhaler home when the school year ends.

IF YOU WANT YOUR STUDENT TO CARRY HIS/HER INHALER:

- Written request from parent/guardian to allow the student to carry the prescribed inhaler and use without supervision (see additional page).
- **WRITTEN AUTHORIZATION FROM THE PHYSICIAN**—can be noted on the Asthma Action Plan & signed by the physician

_____ _____

Parent/Guardian Printed Name Phone Number

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Reviewed by RN: _____ Date: _____

Pierce City Schools

Year_____

Parent or Guardian Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that the student should carry an inhaler at school on the Asthma Action Plan)

- Please notify the teacher, sponsor or coach about your child's asthma when your child will be staying for any school-sponsored after school activities.
- The health office is closed after dismissal and the school nurse is not in the building. It is suggested that the middle and high school students who are involved in these after school activities carry their own inhaler for quick access.

Parent:

- I give consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that the student is not safely and effectively self-administering the medication or violating the agreement below.
- A new Asthma Action Plan signed by the physician and Parent or Guardian/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.
- I will notify the school health team of any change in the medication(s), (ex: dosage, med is discontinued, ect).

_____

Parent/Guardian's Signature Required Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse and will use the correct medication administration technique.
- I agree to follow my prescribing health care professional's medication orders.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree to keep a supply of my medication with me in school and on field trips.
- I agree to report to the school nurse or another appropriate adult, if the school nurse is not available, if any of the following occurs:
  - My symptoms do not improve or continue to get worse after taking the medication.
  - My symptoms reoccur within 2-3 hours after taking the medication.
  - I suspect that I am experiencing side effects from my medication.
  - Other _____
- I understand that permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that I am not safely and effectively self-administering the medication or I am in violation of this agreement.

_____

Parent/Guardian's Signature Required Date

The student has demonstrated knowledge about and proper use and administration of his/her inhaler.

_____ _____

Signature of School Nurse Date

American Lung Association.

My Asthma **Action Plan**
For Home and School

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ **Next flu vaccine due:** _____ **COVID19 vaccine**—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
				☐ Home ☐ School
				☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above. **1-800-LUNGUSA | Lung.org**

Pierce City Schools

Year_____

ASTHMA EMERGENCY PLAN

Student's Name_____ DOB_____ Grade_____ Bus #_____

Student's specific emergencies: _____Student has / does NOT have an inhaler at school.
Student carries inhaler: Yes/No Student has exercise-induced asthma: Yes/No

BASIC FIRST AID FOR ASTHMA

- Remain calm. Stay with the student and have someone get inhaler, if available.
- Have student straddle chair backwards, breathe slowly and deeply in through the nose and out through the mouth.
- Offer sips of tap water.

If no inhaler available and student is not getting better after 15 minutes, call EMS:(9)9-1-1.

If the student's asthma is getting worse: • persistent cough, • mild wheeze • complains of chest tightness	**If there is an inhaler:** • **Shake inhaler 10-15 times. Put on spacer. Student takes a deep breath and breathes out all the way.** • **Student will put mouthpiece in mouth. Press the inhaler to spray one dose.** • **Student will slowly breathe in and hold for the count of ten.** • **Wait 30 seconds and then repeat for a total of _____ puffs. May repeat in ____ hours.**
If emergency inhaler is not helping after 15-20 minutes: • breathing is hard and fast • nose is open wide to breath • ribs show when taking a breath • speaking or walking is difficult • inhale and exhale wheeze is heard	Administer inhaler with spacer as described above: one puff; wait 30 seconds and repeat for a total of____ puffs. **This treatment may be repeated every _____minutes for up to ___ treatments** If on a field trip, notify school and parent If RN not present, main office will notify of RN of status
If student not getting better after 15 minutes: • breathing is harder and faster • nose is open wide to breath • ribs show when taking a breath • speaking or walking is difficult • inhale and exhale wheeze is heard • lips or fingernails are blue	**Call EMS: (9) 9-1-1 and tell them:** • **Who you are** • **Where you are** • **What has happened** • **When you gave inhaler** Administer inhaler with spacer as described above: one puff; wait 30 seconds and repeat for a total of ___ puffs, while waiting for EMS to arrive

If at school: Send to the health room with an adult at first signs of breathing difficulties (wheeze, chest tightness, ect).
The school nurse will assess the student and decide what actions are needed.

If the school nurse is unavailable in the building, notify additional school nurse.

- Ext. 2100—Elementary School Nurse Office
- Ext. 3100—Middle and High School Nurse Office

_____ _____

RN Signature Date