Arizona Autism Charter School
Request for Medical Documentation – Asthma

Student's Name:
Student ID:

Date:

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. New forms are required each school year. The forms attached are:

1. Asthma History form, to be filled out by the parent
2. Asthma Action Plan, to be filled out by the parent and licensed health care provider
3. Consent for Medication Administration Form, to be filled out by the parent and the licensed health care provider.

If you would like to request a meeting with the School Nurse regarding your student's health care needs, please let me know and we can arrange a meeting.

Please complete the Medication Administration Form. Students are allowed to carry emergency asthma medications in school, if the licensed health care provider and parent deems them capable of doing so. These medications can also be kept in the health office.

All completed paperwork and supplies needed to care for your student must be brought to school prior to your student's first day.

Feel free to contact your school health office with any questions.

Thank you,

Jessica Mangieri, RN, BSN
AZACS School Nurse

Arizona Autism Charter School
ASTHMA HISTORY

Student Name _____ DOB _____

ID _____ Grade _____

1. Has your student ever been diagnosed by a licensed health care provider with Asthma? ☐ No ☐ Yes
2. Approximately how often does your student have an asthma attack?

_____

3. When was the last asthma attack?

_____

4. Does exercise cause an asthma attack? ☐ No ☐ Yes If yes, explain.

_____

5. Does weather affect your student's asthma? ☐ No ☐ Yes If yes, explain.

_____

6. What are your student's asthma symptoms?

_____

7. List the medication(s) taken routinely, the dosage, and how often they are to be taken in school. **If the medication is needed during the school day, a Consent for Medication Administration form must be on file.**

_____

8. Does your student have side effects form the medication? ☐ No ☐ Yes If yes, explain.

_____

9. Will your student need treatments with a Small Volume Nebulizer (SVN) while in school? ☐ No ☐ Yes **If yes, a Consent for Medication Administration form is required.**

_____

10. Is there any other information about your student's condition you would like to share with school?

_____

_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION

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)

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 the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – 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 4 hours as needed

Control Medicine(s) ☐Continue Green Zone medicines

☐Add _____ ☐Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is 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.

ARIZONA AUTISM
CHARTER SCHOOLS, INC

Medication Administration in School

Child's Name:		Date of Birth:
Name of Medication:	Dosage:	Time:

I request that authorized school staff give my child the medication noted above, according to the Heath Care Provider's signed instruction on the lower part of this form.

The School agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription Medications: must come in a container labeled with child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the Counter Medication: must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school staff delegated to administer medication.

SIGN HERE

Parent/ Legal Guardian Name	Signature	Date
Work Phone	Cell Phone	

Health Care Provider Authorization to Administer Medication in School

Child's Name:	DOB:
Medication:	
Dosage:	Route:
To be given at the following time(s):	
Special Instructions:	
Purpose of medication:	
Side effects that need to be reported:	
Start Date:	End Date:

SIGN HERE

Signature of Health Care Provider with Prescriptive Authority **License Number**

Phone Number_____ ***Date***_____

Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!