Tempe Union High School District
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 I will arrange a meeting.

Please complete the Consent for 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,

Tempe Union High School District
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.

TEMPE UNION HIGH SCHOOL DISTRICT
Consent for Giving Prescription and Non-Prescription Medications at School
School Year _____ to _____

Student Name _____

School _____ **Student ID** _____

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.):_____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

☐ Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: _____ **Phone No.** _____
(Please print)

_____
Healthcare Provider Signature **Date**

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

_____
Parent/Guardian Home Phone # **Parent/Guardian Work Phone #**

_____
Parent/Guardian Signature **Date**