Health Services Department
937-542-3346

Health Forms for Students with Asthma

Please complete packet and return to your child's school nurse.

What is in this packet?

1) **STUDENT ASTHMA HISTORY**- for parent to describe student's asthma history and list current medications.

2) **MEDICATION AUTHORIZATION FORM / GENERAL MEDICATION FORM**

- **Guidelines for Medications at School** – on page 2 of Medication Authorization Form
- Most oral asthma medications can be given at home before or after school, but if an oral asthma medication must be given at school, please complete this form
- Must be signed by parent and Health Care Provider (HCP)
- Signed form and medication should be brought to school by a responsible adult
- Both the parent (in Parent/Guardian Authorization section) and HCP (in Prescriber authorization section) need to check the box for self-carry if inhaler is not kept in the clinic

3) **ASTHMA ACTION PLAN (AAP)**

- Your HCP's Asthma Action Plan (AAP) form works (but Medication Authorization Form / General Medication Form is also needed) or you may use the school's **ASTHMA ACTION PLAN** included. This form combines the AAP with the Medication Authorization form so you won't need form #3.

If your child already has a current AAP, please bring it in for the school nurse to copy. If not, please ask for one at your child's next appointment.

4) **Authorization for Release of Medical Information**

ADDITIONAL ASTHMA RESOURCE

The **DPS MOBILE HEALTH UNIT (MHU)** offers asthma care at school to supplement the care of your Primary HCP. Care focuses on asthma education, AAP, completion of medication form, and prescription for rescue inhaler at school.

If you are interested in your child receiving MHU services, please complete the ***SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM*** found on the DPS SBHC Website and return to your child's school nurse.

This consent form provides consent for ***both the MHU and the school based health center***. It only needs to be completed once as long as your student remains enrolled in DPS. If you have questions about the MHU, please contact the MHU school nurse at 937-542-3388.

Questions? - Please call your school nurse

DAYTON PUBLIC SCHOOLS

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STUDENT ASTHMA HISTORY—PARENT COMPLETES

So that we can better care for your child at school, please complete this history form about your child's asthma and return to the school nurse. Thank you!

SCHOOL: _____ **DATE:** _____

STUDENT'S NAME: _____ **DOB:** _____ **GRADE:** _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN PHONE NUMBERS: H: _____ **C:** _____ **W:** _____

PARENT E-MAIL ADDRESS: _____

DOCTOR/CLINIC: _____ **PHONE:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR CHILD'S ASTHMA:

1. At what age was your child diagnosed with asthma? _____

2. What signs or symptoms indicate an asthma flare up? _____

3. List your child's asthma triggers: □Exercise □Colds □Smoke (tobacco, fires, incense) □Pollen □Dust □Animals □Strong Odors □Mold/Moisture □Stress/Emotions □Pests □Gastroesophogeal Reflux

4. Are your child's asthma symptoms worse in certain seasons? □Yes □No
   If so, which seasons? □Winter □Spring □Summer □Fall □All Seasons ☐Change of seasons

5. Please list all asthma medications, including any inhalers that your child takes.

   1) _____ 2) _____ 3) _____

6. Has your child been instructed to take a medication daily to control asthma?
   □Yes □No If yes, name of med: _____ Time prescribed: _____

   How often does your child remember to take it? _____

7. How many times in the last 2 years has your child been hospitalized due to asthma problems? _____

8. Does your child wake up coughing during the night? □Yes □No If so, how many nights a month? _____

9. Does your child use a chamber/spacer with his or her inhaler? □Yes □No

10. Does your child have eczema? □Yes □No

11. Allergies: List known allergies to medication, food, air-borne substances, or insect stings: _____
    _____

12. Has your child been tested by a doctor for allergies? ☐Yes ☐No If yes, when? _____

13. When and where was your child's last medical visit for asthma? Date: _____

    Doctor's office (Name) _____ Emergency/Urgent Care (Name) _____

I authorize Dayton Public Schools to communicate and share health information with appropriate school personnel to create an emergency action plan if necessary, and to aid in present and future educational decisions.

Parent Signature: _____ *Date:* _____ *Date Updated:* _____

DAYTON PUBLIC SCHOOLS

Medication Authorization Form
General Medication Form
(Includes Asthma Inhaler and Epinephrine Auto-Injector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	Schoolyear
School Nurse		Phone:	Fax:

Prescriber Authorization

Name of medication	Diagnosis	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector (self-carry) ❑ Not applicable ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler (self-carry) ❑ Not applicable ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief:		
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the prescriber) b) To a student for whom it is not prescribed who receives a dose		
List any known drug allergies and reaction.		

Prescriber signature	Date	Phone	Fax
Prescriber name (print) Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the school nurse for the _____ school year to confer with the licensed prescriber regarding my child's health and treatment issues as they pertain to the medication/diagnosis and his/her attendance, educational, and behavioral management.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

☐ *For Epinephrine Auto-injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

☐ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Received by (school nurse): _____ Date: _____

Adapted from Ohio Department of Health: Revised May 2016, Reviewed Feb 2020
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Guidelines for Medications at School

- DPS has one Medication Authorization form for all medications—oral, injectable, emergency (ex. Epinephrine Auto-Injector, asthma inhalers), and student self-carry medications.
- Any student needing to take medication during school hours **must have a Medication Authorization form** completed and signed by the parent and physician/prescribing healthcare provider.
- **All medication must be in the container in which it was dispensed** by the pharmacist or healthcare provider.
- The medication and Medication Authorization form must be brought together to the school by a parent or responsible adult.
- School personnel may not give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization form must be completed and signed.
- No new medication can be given until the school nurse has reviewed it and checked it in.
- Routine injectable medication can only be given by a school nurse, parent (or parent-designated adult), or self-administered by the student.
- Changes in medication must be provided by the healthcare provider.
- Routine daily medication ordered three times a day or less may not need to be taken at school. The medication should be given before school, after school and at bedtime unless it is time-specific for during the school day. **It is best for morning medication to be given at home.**
- All medication orders must be renewed each school year.
- Parents are notified in writing to pick up all remaining medications at the end of the school year. Per DPS policy, any unused medications not claimed by the last day of school each year will be destroyed.
- Parents will be required to pick up all medications with the exception of inhalers and Epinephrine Auto-Injectors that the student already has written permission from their primary healthcare provider to carry on him/herself.

Original: 2015; Revised: 2015, 2018, 2020

DAYTON PUBLIC SCHOOLS

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SCHOOL ASTHMA ACTION PLAN

Student Name:		D.O.B:	Student ID #:
School:			Grade:
Student's Address:			
Parent/Guardian:	Home:	Cell:	Work:
Other Emergency Contact:	Home:	Cell:	Work:
Allergies to Medication(s):			

Asthma Severity: (Please check if applicable) □Intermittent or □Persistent □Mild □ Moderate □Severe	**Asthma Triggers Identified (Check triggers that apply)** □Exercise □Colds □Smoke (tobacco, fires, incense) □Pollen □Dust □Animals □Strong Odors □Pests □Mold/Moisture □Stress/Emotions □Gastroesophageal Reflux Seasons: □Fall □Winter □ Spring □ Summer □Other:_____	**Date of Last Flu Shot:** ___/___/__	**Inhaler is kept:** □ With Student □ In Classroom □ In School Clinic □ Other: _____

Health Care Provider: Please complete the following information for all zones:

Green Zone: GO! Take Control Medications EVERY DAY

You have ALL of these:
- **Breathing is easy**
- **No cough or wheeze**
- **Can work and play**
- **No symptoms at night**

Peak flow (optional):
Greater than ≥ _____
(More than 80% of Personal Best)
Personal best peak flow: _____

No control medicine required **Always rinse mouth after using your daily inhaled medicine**
_____, _____ puff(s) MDI with spacer _____ times a day.
_____, _____ nebulizer treatment(s) _____ times a day.
_____, _____ take _____ by mouth once daily at bedtime.
Exercise Modifications:
For asthma with exercise, ADD:
_____, _____ puff(s) MDI with spacer 15 minutes before exercise
For nasal/environmental allergy, ADD:
_____

Yellow Zone: Caution! Continue CONTROL Medicine & ADD RESCUE Medicines

You have ANY of these:
- **Cough or mild wheeze**
- **Tight chest**
- **First signs of a cold**
- **Problems sleeping, playing, or working**

Peak flow (optional):
_____ to _____
(50% - 80% of Personal Best)

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue med is administered.

_____, _____ puff(s) MDI with spacer & every ____ hour as needed.

_____, _____ nebulizer treatment(s) & every ____ hour(s) as needed.

Other _____
Call your MEDICAL PROVIDER if you have these signs more than two times a week, or if your rescue medicine does not work! If symptoms are NOT better OR peak flow is NOT improved, go to RED ZONE.

Red Zone: EMERGENCY! Continue CONTROL Medicine & ADD RESCUE Medicines and GET HELP!

You have ANY of these:
- **Cannot talk, eat, or walk well**
- **Medicine is not helping**
- **Getting worse, not better**
- **Breathing hard and fast**
- **Blue lips & fingernails**

Peak flow (optional):
Less than ≤ _____
(Less than 50% of Personal Best)

DO NOT LEAVE STUDENT ALONE! **Call for emergency 911 and start treatment**

_____, _____ puff(s) MDI with spacer & every 20 minutes until paramedics arrive

_____, _____ nebulizer treatment(s) & every 20 minutes until paramedics arrive

Call 911 immediately and call Parent/Guardian

Other: _____

Possible adverse reactions that should be reported to provider:		Possible adverse reaction to child for whom medication is NOT prescribed:
Plan Start Date:	Plan End Date:	Special Instructions:
Provider Phone:	Provider Fax:	Provider Address:

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

□ Student has been instructed in the proper use of his/her asthma medications and is able to carry and self-administer his/her inhaler at school.
□ Student is to notify designated school health personnel after using inhaler at school.
□ Student needs supervision or assistance when using inhaler.
□ Student should not carry his/her inhaler while at school.

Signature/Title: _____

Date: _____

Parent/Guardian:

☒approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications and delivery and monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

Signature: _____ Date: _____

School Nurse: _____ Date: _____

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Authorization for Release of Student Medical Information

Dayton Public Schools

Patient Information

Last name	First name	Middle		
Address		City	State	Zip
Birthdate	Other possible names	Phone #		
School Attending:		Grade:	Home Room:	

Information Requested

☐	Immunization record	☐	Neurological
☐	General / Medical	☐	Surgical
☐	Counseling Record	☐	Orthopedic
☐	Emergency / Urgent care record	☐	Otorhinolaryngology (ENT)
☐	Other:	☐	Ophthamology

Action

☐ Mail Copies
☐ Fax copies

This information may be disclosed to and used by Dayton Public Schools.			The following individual or organization is authorized to make the disclosure:		
Mail to: School					
School Representative		Title			
Address			Address		
City	State	Zip	City	State	Zip
Phone#		Fax#	Phone#		Fax#

Reason Needed

☐	Continuity of Medical Care	☐	Legal Reasons
☐	At request of the Individual	☐	Special Education
☐	School Related	☐	Other:

Authorization

I hearby authorize Dayton Public Schools (DPS) to release and/or receive medical information, to/from the above party. This authorization may include release of information concerning treatment of drug or alcohol abuse, drug related conditions, Human Immunodeficiency Virus (HIV) test results, diagnosis or AIDS related conditions, alcoholism, and/or psychiatric/psychological conditions.

I understand that this authorization shall remain in effect for the school year 20____ - 20____, unless an earlier expiration date is specified in this space (_____). I also understand that I may withdraw this authorization at anytime by written notification to the above parties involved. However, this written notification cannot effect actions that have taken place based on my prior authorization.

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Parent or Guardian	Date
Relationship to Student	
Signature of School Representative	Date

Health Services 2/2004; Rev March 2020