McPherson County Schools – Health Services

Smoky Valley USD 400 McPherson USD 418 Canton/Galva USD 419 Moundridge USD 423 Inman USD 448

ASTHMA HISTORY FORM AND HEALTH CARE PLAN

Student Name:	Date of Birth:
History Taken by:	Date:
Parent/Guardian:	
Home Phone:	Work Phone:
Alternate Contact:	Phone:
Primary Health Care Provider:	Phone: Address:

When was the student's asthma first diagnosed?	
How many times has this student been to the ER or hospitalized for asthma in the past year?	
How many days would you estimate this student missed last year because of asthma?	

What triggers this student's asthma? (check all that apply)

☐Exercise ☐respiratory infection ☐Chalk dust ☐stress ☐strong odors or fumes ☐Indoor dust

☐Pollen ☐Cigarette smoke ☐wood smoke ☐carpets ☐outdoor dust

☐Molds ☐temperature changes ☐mold ☐animals (specify):_____

What does this student do a home to relieve asthma symptoms? (check all that apply)

☐Breathing exercises ☐rest/relaxation ☐drink liquids

☐Medication ☐herbal remedies ☐other:_____

What medication does this student take for asthma (every day and as needed):

Medication_____Amount_____How Often_____

Medication_____Amount_____How Often_____

Medication_____Amount_____How Often_____

What herbal remedies, if any, does this student take for asthma?_____

Does your child use a spacer with inhaler? ☐ Yes ☐ No

Please check special needs related to your child's asthma:

☐Physical education class ☐recess ☐animals in classroom

☐Avoidance of certain foods ☐field trips ☐access to water

☐Sports ☐Transportation to and from school

☐other ☐Observation of side effects from medications

(continue on reverse side)

If you checked any of the above boxes, please describe needs:_____

Asthma Action Plan (To Be Completed By Physician)

Student Name:_____ Grade:_____ Teacher:_____

Medication #1: _____Dosage: _____Time:_____Route: _____

Medication #2: _____Dosage: _____Time:_____Route: _____

If This Happens	Do This	Do This Next
***Student has no asthma symptoms** *Student can do usual activities *The student can sleep w/o symptoms	*Encourage student/family to maintain therapy at home	*Continue to monitor for changes or asthma symptoms
***Student has asthma symptoms** • Shortness of breath • Wheezing or whistling sound when exhaling • Cough • Chest tightness • Rapid breathing	*Administer the following Medication: ☐ _____ ☐ _____ *Allow student to rest for 15 minutes. May encourage student to put hands on top of the head to relax chest muscles *Have student take sips of water to help thin secretions	*Monitor student for response to medication ☐If symptoms resolve student may return to class/normal activity but continue to monitor for changes ☐ If symptoms do not improve after 1 treatment you may repeat treatment and contact parents ☐ If symptoms do not improve or worsen after ordered treatments seek medical care
***If student has severe symptoms:** • Persistent Cough • Extreme shortness of breath • Retractions between ribs or at the neck • Trouble talking • Lips or fingernails are blue • Struggling to breathe	☐ Seek emergency medical care, call 911 ☐ Contact parents ☐ Administer Epipen for severe asthma symptoms ☐ EpiPen Jr. ☐ Epi Pen	**Directions for EpiPen:** 1) Pull off blue safety cap 2) Place orange tip on upper outer thigh at right angle to leg, through clothes. If thigh cannot be used, use the deltoid muscle on upper arm. 3) Press Epipen hard into thigh until auto-injector mechanism functions. Hold in place 10 seconds, then remove. 4) Give EpiPen to EMS personnel or discard in sharps container.

Licensed Health Care Provider Signature _____Date _____
(M.D., D.O., D.D.S., A.R.N.P., or P.A.)

PARENT / GUARDIAN PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE

I hereby give my permission for my child to take the above prescribed medication at school as ordered. I understand that it is my responsibility to furnish the medication in the original container appropriately labeled by the pharmacy / manufacturer or physician stating the name of the medication, the dosage, time to be given, and number of days to be administered at school. Any school employee who administers any medication in accordance with written instructions from the prescribing health care provider shall not be liable for damages as a result of any adverse drug reaction suffered by the student. If the student self-administers the medication, I acknowledge that the above named student has been instructed on self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication. I understand the school policy regarding medication.

I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises. I may revoke this consent to release information in writing and dated at any time except to the extent that action has been taken or information disclosed pursuant to signed consent. This consent shall remain in effect for a period of one year from signature date. To revoke this authorization, I should contact: my child's school or McPherson County Special Education Cooperative, 514 N Main, McPherson, KS 67460. Once information is disclosed, it may no longer be subject to HIPAA protections.

EMERGENCY MEDICATION ONLY: My child may carry inhaler / emergency medication (asthma, severe allergic reaction, diabetes management) with him/her. He / She has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed.

Parent/Guardian Signature_____Date_____

Printed Name of Parent/Guardian_____