Asthma Inhalers at Crossroad Academy

So that the best care can be provided for your child, please complete the attached form and return it to the school nurse before the first day of school. If any changes occur during the school year, please notify the school nurse.

Child's Name_____

Name of Medication	**Dose**	**Frequency of Use**

I give school personnel permission to assist my child with the administration of the inhaler listed above.

Parent's signature _____ Date_____
Parent's emergency phone numbers _____ & _____

Physician's name_____phone number_____
Please submit Asthma Action Plan completed and signed by your physician

Choose one (Circle):

Option #1

The student comes to the Health Office where the inhaler is kept, and uses it under supervision. The advantage is that the medication will be used correctly, in the proper amount, and records will be kept. The inhaler will be available to the student during school hours where it can be used as needed. All medications brought to school must be in their original container, with a signed parental permission note (above) giving the child's name, dose and schedule for medication to be given. A physician's signature or order is also required.

Option #2

Qualified students will be allowed to carry their inhalers. The advantage is that it is immediately accessible. A spare inhaler provided by the parent may be kept for them in the Health Office should they forget theirs or in case the medication runs out.

Contract Between Student, Parent, and Nurse for Permission to Carry Inhaler

1. Student has demonstrated to the nurse correct use of inhaler.
2. Student agrees never to share the inhaler with another person.
3. Student agrees that if, after two puffs, there is not marked improvement, he/she will go to the Health Office immediately.

Student's Signature_____ Date_____

Parent's Signature_____ Date_____

OVER

Student Asthma Information

Student's Name _____Grade:_____

Please describe the type of symptoms the child experiences, i.e. wheezing, coughing, tightness, other...

What usually helps if an attack occurs?

Other medications my child is on:

Medication Name	Dose	Frequency
Medication Name	Dose	Frequency
Medication Name	Dose	Frequency

Medication side effects your child experiences:

Does your child use a peak flow meter?

Additional information/instructions:

Number of times child has been taken to an emergency facility for an acute attack of asthma in past 12 months:

Please submit an Asthma Action Plan completed and signed by your physician