Asthma Inhalers at Crossroads Academy

In order for us to provide the best care for your student, 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.

Student Name: _____ Date of Birth: ____/____/_____ Grade: _____

Inhaled Medication Name: _____
Dosage: _____

Instructions for use (how many puffs, how often, under what symptoms to administer):

_____

_____

_____

Please submit an Asthma Action plan, signed by your student's primary care, pediatrician, or pulmonologist to healthoffice@crossroadsacademy.org before the first day of school. This needs to be updated every 12 months and MUST be signed by the prescriber. This will serve as required documentation for prescription medication to be administered in school.

I give school personnel permission to assist my child with the administration of the inhaler listed on the Asthma Action plan.

Parent's Signature:_____ Date: _____

Parent's Name: _____

Select an option below:

☐ **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.

For Option #2 only (**to be signed with school nurse**)

Student's Signature: _____ Date:_____

Student's Name: _____

School Nurse's Signature: _____ Date:_____

School Nurse's Name: _____

Student Asthma Information

What usually helps if an attack occurs? _____

_____

Other medications your student is taking: _____

Medication side effects your student experiences: _____

_____

Has your student been hospitalized or been seen in the emergency department for breathing-related issues in the last 12 months? Yes _____ No _____

Does the student use a peak flow meter? Yes _____ No _____

Please describe the type of symptoms the student experiences, i.e. wheezing, coughing, tightness, other: _____

_____

_____