Ridgefield Public Schools

Student Asthma Information Form

Place Photo ID

here

PARENT FORM

Student's Name_____
DOB _____ Grade _____ School Year _____
Address _____
_____
Parent's Names _____
_____
Parent's Daytime Phone: Mother _____
Father _____
Emergency Contact # 1 Name_____ Relationship _____ Phone _____
Emergency Contact # 2 Name_____ Relationship _____ Phone _____
Emergency Contact # 3 Name_____ Relationship _____ Phone _____
Health Care Provider: _____Phone _____
Asthma Specialist: _____ Phone _____
Allergies to Foods, Medications, Bee Stings or Environmental: _____
_____

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma. (circle)
   (Not severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days would you estimate he/she missed school last year due to asthma? _____

4. What triggers your child's asthma attacks? (Please check any that apply)

   ___ Illness ___ Emotions ___ Medications ___ Foods
   ___ Weather ___ Exercise ___ Cigarette smoke ___ Chemical odors
   ___ Allergies (please list) _____ ___ Fatigue
   ___ Other (please list) _____

5. What symptoms does your child display during an asthma attack? (Please check any that apply)

   ___ Wheezing ___ Coughing ___ Short of breath ___ Chest tightness
   ___ Other (please list) _____

6. What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply)

   ___ Breathing exercises Takes medication: ___ Inhaler
   ___ Rest / relaxation ___ Via nebulizer
   ___ Drinks liquids ___ Oral medication
   ___ Other (please describe) _____

7. Does your child check his/her peak flow at home?
   ___ Yes (If yes) Baseline Peakflow _____ Personal Best Peakflow_____ Date last checked _____
   ___ No

8. What medications does your child take and how often?

   Every day _____
   Just for attacks _____
   Before exercise _____
   Just certain times of the year or when ill _____

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9. What medications will your child need to take in school? (Please list name of medication and when it is to be taken) _____
_____
_____

10. What if any, side effects does your child have from his/her medication? _____
_____

11. Does your child use a spacer device when using his/her inhaler? ___ Yes ___ No

12. Will your child need to evaluate his/her peak flow before the administration of medication?
___ Yes___ No

13. Does your child self administer his/her own medication at home? ___ Yes ___ No
(Only Middle and High School students are permitted to self administrate unsupervised outside of the Health Office)

14. Does your child need any special considerations related to his/her asthma while at school? (Check any that apply and describe briefly)
___ Modified PE class _____
___ Modified outdoor recess _____
___ No animal pets in classroom _____
___ Avoiding certain foods _____
___ Emotional or behavioral concerns _____
___ Special consideration while on field trips _____
___ Special transportation to and from school _____
___ Observation of side effects from medications _____
___ Need to take medication during the school day _____

15. What plan of action would you prefer school personnel to take in an asthma attack?
_____
_____
_____
_____
_____
_____

16. What plan of action would you prefer school personnel to take if your child suffers a severe asthma attack, not relieved by medication or rest?
_____
_____
_____
_____
_____
_____

17. Would you like to discuss your child's asthma condition with the school nurse? ___ Yes ___ No
Best time to contact you _____

Ridgefield Public Schools

Student Asthma Information Form

Student Name: _____ Grade/Teacher:_____

Does your child take/use any medication/equipment/supplies for this medical condition at home? (YES / NO)(Circle one)

If yes, please list all medications/equipment/supplies used at home:

_____

_____

_____

_____

_____

In the event your child cannot get home due to an emergency, do you wish a supply of the listed medications/equipment/supplies be kept at school? (YES / NO) (Circle One)

(Parent to provide equipment/supplies or medication and medication authorization forms for each medication)

_____ _____
Signature of Parent/Guardian Date

Nurse to complete:

Medications/Equipment/Supplies received (List):

_____

_____

_____

_____

_____

_____ _____
Signature of Nurse Date

Form H-6

RIDGEFIELD PUBLIC SCHOOLS

School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name/ Strength _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work #: _____

I DO / DO NOT (circle one) wish the medication BROUGHT on field trips

I DO / DO NOT wish medication ADMINISTERED on shortened days _____ _____
Signature Date

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication (inhalers, EpiPens or other medications approved by the School Medical Advisor and Head Nurse) may be authorized for middle and high school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self administration: ☐ Yes ☐ No _____ _____
Signature Date

Parent/Guardian authorization for self administration: ☐ Yes ☐ No _____ _____
Signature Date

School nurse approval for self administration: ☐ Yes ☐ No _____ _____
Signature Date

Received by _____ Date of Receipt/Form _____ Date of Receipt/Medication _____

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