Ridgefield Public Schools

Student Asthma Information Form

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  ___ Oral medication
   ___ Drinks liquids  ___ 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
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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