ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

To the parent/guardian of_____
School records specify that your child has ASTHMA.

In order to provide better health services for your child in school, we need to know if this is currently a problem and if your child needs special observation for this condition in school.

Please fill out and return this form to me at school. If you have any questions or concerns, please feel free to contact me at_____. All medical information is confidential and will be shared only with the teaching staff working with your child.
Thank you.

_____
Name Title

Your child's asthma triggers are (check all that apply):
_____ Allergies such as: _____ Plants, dust ____ Animals _____ Other
_____ Exercise _____Cold Air _____Infections/Bronchitis

Your child's signs of asthma attack are (check all that apply):
_____ Rapid, labored breathing _____Coughing _____Wheezing
_____ Tightness of chest _____Shortness of breath
_____ Other:_____

Your child's asthma is treated by (check all that apply):
_____ Regular medications, every day
_____ Medications when an attack occurs
_____ Nebulizer treatments every day
_____ Nebulizer treatments when an attack occurs
_____ I haven't had to treat the asthma since _____

If your child uses a Peak Flow Meter, what is his/her range? _____

Please list your child's medications. _____
_____

If these medications need to be available during school hours, a Medication Authorization Form will need to be completed. Obtain forms from school clinic.

Who is your doctor? _____

When was the last time your child saw the doctor? _____

_____ _____
Signature of Parent or Guardian Date

Revised July, 2011

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

ASTHMA MEDICAL MANAGEMENT PLAN
SCHOOL YEAR _____

Name: _____ Grade: _____ Date of Birth: _____

Teacher: _____ Room: _____

Place ID Photo Here

Parent/Guardian Name: _____ Ph: (H) _____
Address: _____ (W)_____
_____ (C) _____

Parent/Guardian Name: _____ Ph:(H)_____
Address: _____ (W)_____
_____ (C)_____

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Asthma Healthcare Provider: _____ Phone: _____

Other Healthcare Provider: _____ Phone: _____

Daily Asthma Management Plan

· Identify the things that start an asthma episode (check all that apply to the student)

[ ] Exercise
[ ] Chalk Dust
[ ] Animals
[ ] Molds
[ ] Strong odors or fumes
[ ] Change in temperature
[ ] Pollens
[ ] Other _____
[ ] Respiratory Infections
[ ] Carpets in the room
[ ] Food _____

Comments: _____

·Control of School Environment

(List any environmental control measures, pre-medications and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____
_____

·Peak Flow Monitoring

Personal best peak flow number: _____ Monitoring Times: _____ _____ _____

·Daily Medication Plan

	Name	Amount/Dose	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

_____

or has a peak flow reading of _____

· Steps to take during an asthma episode:

1. Give medications as listed below.
2. Have student return to classroom if _____
   _____
3. Contact parent if _____
   _____
4. Seek Emergency Medical Care if the student has any of the following:
   No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   Peak Flow of _____
   Hard time breathing when:
   Chest and neck pulled in with breathing
   Child is hunched over
   Child is struggling to breathe
   Trouble walking or talking
   Stops playing and cannot start activity again
   Lips or fingernails are gray or blue

· **Emergency Asthma Medications**

	Name	Amount/Dose	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments / Special Instructions

_____
_____
_____

For Inhaled Medications

[ ] I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

[ ] It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

_____ _____
Physician's Signature Date

_____ _____
Parent's Signature Date

ST. JOHNS COUNTY SCHOOL DISTRICT

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student's Name: _____ Date of Birth:_____

School: _____ Grade: _____ Teacher/Homeroom: _____

MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment: _____Amount (Dosage):_____

Time to be given: _____Date to start: _____Date to end:_____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions (i.e., may carry epi-pen/Glucagon on person)**: _____-_____**

_____

Physician ordering medication: _____
(Print)

Physician's address: _____

Physician's phone: _____FAX: _____

Physician's signature: (required for all medications)_____

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them.

I authorize the physician to release information about this condition to school personnel.

_____	_____	_____
Parent/Guardian Signature	Work/Home/Cell Phone	Date

STUDENTS: POSSESSION OF INHALERS AND EPIPENS - Florida Statute 1002.20

*Florida law state asthmatic students or students with life-threatening allergic reactions, may carry a prescribed metered dose inhaler or epipen on his/her person while in school with approval from his/her parents **and** physician. The above named child may carry and self-administer his/her metered dose inhaler or epipen.*

Parent/Guardian Signature:_____ Date:_____

Physician's Signature: (required) _____ Date:_____