Confidential Health Assessment: Management of Asthma at Home
*Information for Individualized Healthcare Plan or Asthma Action Plan

Completed by school nurse with parent and pupil

Pupil:	**DOB:**	**Date:**
School:	**Teacher/Rm:**	**Grade:**
School Nurse:	**Information provided by:**	

1. History & current medical status

- When was child diagnosed with asthma? _____
- Asthma severity classification: ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent ☐ Classification unknown
- How many days in the last 2 weeks has child had asthma symptoms? _____
- How many nights in the last month has child had asthma symptoms? _____
- How many times in the last 3 months has child been to ED or Urgent Care for asthma or related symptoms? _____
- How many times has child ever been hospitalized for asthma? _____
- Does asthma interfere with child's normal activity? (Symptoms cause child to stop/rest at PE, recess or home activities)
  ☐ No ☐ Yes: Some limitation ☐ Extremely limited ☐
- How many days of school has the child missed in the past month because of asthma? _____
- How many times in the last 2 weeks has child used quick-relief (rescue) medication? (exclude exercise-induced asthma) _____
- When was child's last visit to healthcare provider for asthma evaluation? _____
  Reason: ☐ Asthma exacerbation ☐ Regularly scheduled follow-up
- Additional information: _____

2. Individual symptoms of acute asthma episode:

☐ Coughing ☐ Breathing hard & fast ☐ Shortness of breath ☐ Breathlessness ☐ Wheezing ☐ Mouth breathing
☐ Chest/throat tightness ☐ Other symptoms: _____
☐ Child's verbal complaints: _____

3. Identify what may cause an asthma episode (triggers):

☐ Exercise	☐ Animal fur/feathers	☐ Paint	☐ Strong odors/fumes:
☐ Respiratory infection	☐ Dust mites	☐ Perfume	_____
☐ Cold weather	☐ Cockroaches	☐ Pollen/grasses	☐ Food: _____
☐ Change in temperature	☐ Molds	☐ Pollen/trees	☐ _____
☐ Air pollution	☐ Smoke	☐ Pollen/shrubs, flowers	☐ _____

List any environmental control measures, pre-medications and/or dietary restrictions needed to prevent an asthma episode. _____

4. Does child have an asthma action plan? ☐ Yes (request a copy) ☐ No (Discuss obtaining Asthma Action Plan)

5. Does child use a peak flow meter? ☐ No

☐ Yes—Type of meter: _____ Monitoring times: _____

Personal best peak flow number: _____

6. Daily controller medication (s) used at home:

	Medication	Dose	Schedule	Route/method
(1)	_____	_____	_____	_____
(2)	_____	_____	_____	_____

7. Quick-relief (rescue) medication used at home:

Medication: _____ Dose: _____ Route/method: _____

How soon do symptoms improve after use of quick-relief medication? _____

Management of Asthma at Home

Pupil:	DOB:	Date:

8. Emergency asthma medication (epinephrine autoinjector): ☐ None prescribed
Medication: _____ Dose: _____ Route/method: _____

9. Actions taken at home during an asthma episode: _____
When are 911 emergency services called at home: _____ Date of last 911 call: _____

10. Medication needed at school:

☐ **Medication delivery method:** ☐ Inhaler/holding chamber( ) ☐ Inhaler/open mouth technique
☐ Inhaler/closed mouth technique ☐ Nebulizer ( ); monitor heart rate during treatment ☐ Yes ☐ No

☐ **Quick-relief medication**
☐ As needed for asthma symptoms ☐ Before exercise
☐ Regularly during asthma exacerbation per authorized healthcare provider orders

Medication:_____ Dose: _____ Schedule:_____ Route/method: _____

☐ **Emergency medication (epinephrine autoinjector) needed at school:**

Medication:_____ Dose: _____ Schedule:_____ Route/method: _____

(Explain legal requirements for administration of medication in school setting.)

11. Describe child's knowledge of his/her asthma symptoms and management:_____

- **Child can correctly self-administer quick-relief medication:** ☐ with supervision ☐ without supervision

☐ **Parent requests that child carry inhaler at school**
(Explain process for independent management of asthma in the school setting.)

12. Emergency Response Plan in school setting: _____
(Explain legal requirements/school district policy; 911 will be called according to standard school emergency procedures.)

13. Physical education participation: _____
Modifications needed: _____

14. Field trip plan: _____

15. Equipment, supplies, forms provided by parent:

☐ Quick-relief inhaler: ☐ MDI ☐ Dry Powder Inhaler (DPI)
☐ Nebulizer/medication in unit-dose vials
☐ Peak flow meter
☐ Asthma Action Plan
☐ Medication authorization form signed by authorized healthcare provider and parent

16. Disaster preparedness plan for school: _____

17. Concerns about school attendance: _____

18. Name, address, phone and fax number of authorized healthcare provider:

_____
Authorized healthcare provider: ☐ Family practitioner ☐ Pediatrician ☐ Asthma/allergy specialist
Pupil's clinic identification number: _____
☐ HIPAA-compliant authorization for exchange of information signed by parent.

19. Notes:

*May be used with Confidential Health Assessment form (Appendix D) in Section 2, ***The Green Book: Guidelines for Specialized Physical Healthcare Services in School Settings, 2nd Ed.***

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
HEALTH HISTORY INFORMATION

Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

The above student has the following condition(s):

1. _____
2. _____
3. _____

Please provide us with the following information so that we may have a better understanding of your child's needs while at school.

1. Is your child under the care of a physician for the above condition(s): Yes/No
2. Has your child had a problem with this condition in the last year? Yes/No

   Physician's name: _____ ***Phone #:*** _____
3. Should your child's activities at school be restricted in any Way? (Please explain) Yes/No

   _____

   _____
4. Does your child taken medication for this condition? Yes/No

   Name of medication*:* _____ Dosage*:* _____

   Name of medication*:* _____ Dosage*:* _____

   Name of medication*:* _____ Dosage*:* _____
5. What action do you want the school to take when your child is sent to the Health Office for a problem?

   _____

   _____
6. Please list any other information that might be helpful in caring for your child.

   _____

   _____

   _____

   _____

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION: I authorize the school nurse to communicate with the physician when necessary. I hereby give my permission for exchange of confidential information contained in the record of my child.

Parent Signature: _____ **Date:** _____

Reviewed by Health Services _____ **Date:** _____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
EMERGENCY ASTHMA CARE PLAN

Student: _____ **DOB:** _____ **Grade:** _____

EXCHANGE CONFIDENTIAL INFORMATION: (Please Initial if the following apply to your student).

1. ___ **Afterschool care:** Our child attends the afterschool daycare program "TLC" and the School District is authorized to provide them with guidelines for the treatment of our child in the event health care service is needed.
2. ___ **School Transportation:** Our child rides the school bus (other than field trips), and the School District is authorized to provide them with guidelines for the treatment of our child in the event health care service is needed.

Health Care Provider/Physician:

We grant permission for SVUSD to Exchange confidential information contained in our child's medical record with the physician noted below, and Disclose emergency health information to individuals at our child's school as needed, either as a written or verbally. We will maintain current phone numbers with the school office in case 911 is called.

PARENT CONSENT FOR HEALTH CARE AT SCHOOL

The signatures below provide authorization for the above written orders and show agreement that all procedures must be implemented in accordance with state laws and regulations. We will notify the School if there is a change in the student health status or change of physician. If changes are needed to medication, or the treatment plan, we will provide new physician's order, new written authorization or a signed addendum of this form must be provided. **This authorization is for a maximum of one year**.

We (I) understand that the District will appoint a qualified designated person(s) who will be performing the above-mentioned health care service, in accordance with California Education Code. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure that has been approved by our child's physician.

PARENT'S AUTHORIZATION

Parent Signature**:** _____ Date: _____

Health Services: _____ Date: _____

EMERGENCY CONTACT INFORMATION:

Mother: _____ Hm: _____ Cell: _____ Wk: _____

Father: _____ Hm: _____ Cell: _____ Wk: _____

Emergency Contact: _____ Hm: _____ Cell: _____ Wk: _____

Doctor: _____ Hm: _____ Cell: _____ Wk: _____

Saddleback Valley Unified School District
Medication Authorization Form

E 5141.21

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____ Birthdate: _____

School:_____ Teachers Name:_____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature:_____ Date:_____

Telephone: (Work)_____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication:_____ Dose:_____ Route:_____ Time: _____

If PRN: Amount of time between doses_____ Maximum number of doses_____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

By signing below, I verify the information is correct and medication may be administered by a trained, unlicensed professional.

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone_____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication:_____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:
Reviewed by:_____ Date: _____

This request is valid for a maximum of one year.

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Saddleback Valley Unified School District
Medication Authorization Form

E 5141.21

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

***Name of Student**:* _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

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