Greensburg Salem School District

ASTHMA INHALER PERMISSION FORM

7/10

House Bill 1113 was passed by the State House of Representatives allowing elementary and secondary students diagnosed with asthma to self-treat asthma in the school setting under specified conditions. The following is the Greensburg Salem School District Asthma Medication Policy:

1. A District *Asthma Inhaler Permission Form* must be completed and signed by the student's physician as well as the parent/guardian. This form will include permission from the physician as well as the parent/guardian authorizing the student to carry and self-administer their inhaler. This medication permission form will be kept in the nurse's office.
2. The medication must come in the original container/box with the prescription label in it stating the student's name, medication name, dosage, and frequency of doses. The medication must be carried in the prescription box at all times.
3. The student must demonstrate to the nurse the correct procedure for self-administration before permission will be given to carry the inhaler.
4. The student is ***REQUIRED*** to notify the school nurse immediately following the use of the inhaler for evaluation.
5. If the student abuses or ignores the school policies, the school can confiscate the inhaler and remove the privilege to carry the inhaler for self-administration.
6. The parents must sign a waiver relieving the school of responsibility for the benefits or consequences of the medication. Also, included would be a statement that the school bears no responsibility for insuring that the medication is taken.

The following information should be completed by the parent/guardian and signed by your physician. Parents should then sign where indicated and return BOTH pages of this form to the school nurse as soon as possible.

Please print

_____ *Student's Name* _____ *Grade and Teacher* _____ *School* ____/____/____ *Date of Birth*

Check appropriate block(s)

Asthma Severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other_____

_____ *Medication* _____ *Dosage* _____ *Frequency* _____ *Peak flow range if applicable*

_____ *Physician's signature* _____ *Physician's phone #* ____/____/____ *Date*

I give permission for my child: *(print student's name)* _____ to carry the asthma inhaler prescribed by his/her physician. I understand that he/she must follow the rules listed above. I will notify the school of any changes in medication or my child's condition. _____ *Parent/Guardian's signature* ____/____/____ *Date*

— or —

I prefer my child *(print student's name)* _____ to keep their asthma inhaler in the nurse's office and use it under the nurse's supervision. The advantage of this is that the medication will be used correctly and records will be kept by the nurses. _____ *Parent/Guardian's signature* _____ *Phone #* ____/____/____ *Date*

OVER

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7/10

Student Asthma Information Sheet

Student's Name _____ Homeroom _____ School Year _____ - _____

Describe the type of symptoms student experiences (e.g. wheezing, coughing, tightness, other) _____

What usually helps if an attack occurs? _____

Medication student takes - (please list the name of the medication(s), dosage and frequency)

Side effects of medications that student experiences: _____

Does your child use a peak flow meter? Yes ____ No ____

Number of times student has had to be taken
to an emergency facility for an acute attack of asthma in the past 12 months? _____

Additional Information/Instructions: _____

PLEASE CONTACT THE SCHOOL NURSE IF YOUR CHILD'S INFORMATION OR CONDITION CHANGES DURING THIS SCHOOL YEAR

Thank you for your help in providing the best care for your child

NURSE: _____ Phone: _____