BISHOP WATTERSON HIGH SCHOOL
Exemplary Catholic Education,
Rooted in Faith, Committed to Excellence

Health forms for students with Asthma

Please complete packet and return to the nurse at your child's school.

What is in this packet?

1) **Asthma Questionnaire** to describe student's asthma

2) **Release of Information** allows the doctor to talk to the school nurse if there are any questions

3) **Guidelines for Medicines** at School – parent reference

4) **Asthma Medication Authorization** - must be signed by parent and doctor and brought to school with the asthma medication

5) **Medication Authorization** - must be signed by parent and doctor and brought to school with any additional medication

Questions - Please call your school nurse: 614-268-8671 ext.29

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Asthma Questionnaire

To be completed by parent

Student:		School Year:
DOB:	Class/Grade:	
Parent:		Cell:
Parent:		Cell:
Emergency Contact:		Phone:
Physician:		Phone:

This information will provide the school nurse with a better understanding of the child's needs. This questionnaire needs updated and completed each school year.

Has this child been diagnosed with asthma by a healthcare provider? ☐ Yes ☐ No

Note: Bring medical documentation to the school nurse. **AFTER** the nurse has received documentation from the child's **healthcare provider,** school staff will be notified of the allergies and emergency plans.

Asthma Triggers

Exercise Illness Weather Smoke/Fumes/Odors Animal_____Other_____
Indoor allergies_____
Outdoor allergies_____
Other_____

Early Symptoms or Warning Signs

Please list:

Asthma Medicine

Typically, how often does your child need to use a rescue medication? _____
How does your child manage an asthma episode at home? _____
☐ rescue inhaler ☐ nebulizer ☐ other_____

Daily medication name:	**Dosage:**	**When taken:**
"As needed" or rescue medications:	**Dosage:**	**When used:**
☐ Albuterol MDI	90mcg 2 puffs	every four hours as needed
☐ Other:		

What should school personnel do to help your child during an asthma episode?
☐ allow to rest and cool down ☐ give sips of water ☐ give rescue inhaler as ordered
☐ other_____

If the student does not respond to medication during as episode, the school will notify the parent/guardian and call 91

Any other information or chronic health problems that would be helpful to know?

I authorize St. James the Less to communicate with the student's healthcare providers, teachers and other appropriate school s about the asthma.

Parent Signature: _____Date: _____

RETURN TO SCHOOL NURSE IMMEDIATELY!

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AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and St. James the Less Catholic School.

_____Obtain Information From: _____

_____

_____

__x___Release Information To: Bishop Watterson High School

c/o Tonya Friend BSN, RN

School Nurse

P- (614) 268-8671 ext. 290

F- (614) 268-0551

___x__Medical Information/Records –

- immunization record; TB test result/ records
- copy of most recent physical exam on file
- medication authorization to give medication at school
- health appraisals/screenings
- lab work
- psychological information/records
- speech and hearing evaluation
- IEP
- Medical records; healthcare provider notes/summary

_____Other Information, as specified: _____

_____

_____

This information is to be used by the School Nurse for continuity of care in the school setting.

_____ _____

Parent/Guardian Signature Date

Electronic signature permitted

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Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions. The medication cannot be expired.
  - The label must match what is on the Medication Authorization Form.
  - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
  - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

- ***All EXPIRED medication must be picked up by the parent/guardian on the last day of school or it will be discarded.***

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Asthma Medication Authorization

to access and use prescribed medications during school ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ HR/Grade _____

Healthcare Provider to Complete:

St. James the Less urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of_____

Medication_____ **Dosage**_____ **Route**_____

Frequency: ☐ Every _____hours PRN **- OR -** ☐ Give at: _____(time/s) **Begin Date** _____**End Date** _____or End of school year

Instructions and precautions_____

Possible side effects to report to the healthcare provider_____

If the medication does not provide relief_____

Other medications prescribed to this student (home & school) _____

For asthma inhaler: The student has demonstrated the proper use of the medication? ☐**yes** ☐**no**
The student is capable and may carry and self-administer medication per ORC 3317.716 and 3313.718. ☐**yes** ☐**no**

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____**or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's inhaler will be stored in the school medication cabinet to ensure its availability for their use and will have the assistance of trained staff as needed unless he/she is authorized to self-carry and administer.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- *I authorize St. James the Less staff to communicate with the student's healthcare provider as needed.*
- I release and agree to hold the Diocese of Columbus, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
- **My student may self-carry and self-administer his/her inhaler as prescribed above, at school/school events if determined capable by myself, healthcare provider and school nurse and understand my student is to report to school clinic/office after using medication. ☐yes ☐no**

Parent/Guardian Signature _____ **Date**_____

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Medication Authorization

to access and use prescribed medications during school ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ HR/Grade _____

Healthcare Provider to Complete:

St. James the Less school urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of_____

Medication_____ Dosage_____ Route_____

Administration Time(s)_____ OR ☐ Every _____ hours as needed for_____

Beginning Date _____ Expiration Date_____/End of school year

Instructions: _____

_____

Precautions and possible side effects_____

Other medications prescribed to this student (home & school) _____

_____

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____**or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.
- I authorize the student named above to receive the medication as ordered above.
- I understand the medication must not be expired, be in the original container and labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- *I authorize St. James the Less school staff to communicate with the student's healthcare provider as needed.*
- I release and agree to hold the Diocese of Columbus, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____