HEALTH SERVICES

RICHARDSON INDEPENDENT SCHOOL DISTRICT

RISD ~Where all students learn, grow, and succeed.

Dear Parents,

You are receiving this letter because you have indicated your child has asthma. To ensure quality care is given to your child please make certain you return all required forms indicated in the checklist below to the school nurse. Please note that some forms require a physician's signature.

I also want to take this opportunity to address a concern regarding the use of inhalers. Due to recent changes in the manufacturing of inhalers, it is difficult to tell when an inhaler is out of medication. Even when empty, propellant remains in the inhaler and continues to produce a spray when pumped. Each type of inhaler contains a different number of available doses, and very few have built-in counters to help the user know when the inhaler is almost empty. Many inhalers now also require "priming" before administering the medication if the inhaler has not been used in a set amount of time. This "priming" decreases the number of doses remaining as well. Often times, unless strict counting of doses and priming has been monitored, the only sign that an inhaler may no longer contain the medication is the asthmatic's lack of improvement in breathing after using the inhaler or more frequent use of the inhaler when typically taken preventatively before activity.

When your child is having an asthma attack, we want to make certain that there is an adequate supply of medication in your child's inhaler. In order to be pro-active, RISD Health Services is requesting that when possible, parents provide the school nurse with a brand new inhaler that stays at school. This would enable the school nurse to closely monitor the number of doses/primes and give adequate notice to parents of the need to replace the inhaler before the child needs it emergently and the inhaler is empty. When a brand new inhaler cannot be provided to the school nurse, it is important to let the school nurse know how old the inhaler is, how often the child uses it, and how often priming is performed so that an estimate of the number of doses remaining can be determined.

All students with asthma need to bring:

- ☐ Asthma Questionnaire
- ☐ Emergency Plan – **Physician's Signature Required**
- ☐ Medication Form (each medication requires a separate form)
- ☐ Medication(s) with prescription label(s) attached

If your child uses an inhaler, you may also need:

- ☐ Self-Administration form (gives permission by the physician for your child to carry their inhaler and use it on their own) – **Physician's Signature Required**

If your child uses a nebulizer, you will also need:

- ☐ Mouthpiece or Face Mask, and tubing for nebulizer
- ☐ Nebulizer machine

Thank you,

HEALTH SERVICES
Richardson Independent School District
Asthma History Questionnaire
*This form is to be renewed annually at the beginning of each school year

Student: _____ Date of Birth: _____ Gender: _____ Grade/Teacher: _____

Emergency Contact Information		Home:	Work:	Cell:
Mom/Guardian:				
Dad/Guardian:				
Other:				
Doctor:				

When was your child diagnosed with asthma? _____

Please rate the severity of his/her asthma. (not severe) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (severe)

What triggers your child's asthma attacks? Check all that apply.

☐ Allergies ☐ Fatigue ☐ Weather changes ☐ Cigarettes/smoke ☐ Emotions
☐ Exercise ☐ Illness ☐ Medications ☐ Chemical odors ☐ Food

How many days would you estimate he/she missed from school last year due to asthma? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 15+

Does your child use a Peak Flow Meter at home? ☐ Yes ☐ No If yes, what is his/her personal best? _____

What does your child do at home to relieve wheezing during an asthma attack? Check all that apply.

☐ Inhaler ☐ Nebulizer ☐ Other Medication ☐ Rest ☐ Liquids ☐ Breathing exercises
☐ OTHER (please describe): _____

What medications does your child take?
Medication: _____ How often? ☐ Daily ☐ As needed ☐ Before exercise Does this medication need to be given at school? ☐ Yes ☐ No
Medication: _____ How often? ☐ Daily ☐ As needed ☐ Before exercise Does this medication need to be given at school? ☐ Yes ☐ No
Medication: _____ How often? ☐ Daily ☐ As needed ☐ Before exercise Does this medication need to be given at school? ☐ Yes ☐ No
Medication: _____ How often? ☐ Daily ☐ As needed ☐ Before exercise Does this medication need to be given at school? ☐ Yes ☐ No

**A separate request for medication administration is required for each medication to be given at school.*

How many times has your child been treated in the Emergency Department for his/her asthma in the last year? _____

Has he/she been hospitalized for asthma related problems in the last year? ☐ Yes ☐ No How many times? _____

Does your child need any special considerations related to his/her asthma while at school? ☐ Yes ☐ No

If yes, please explain. _____

Additional information:

Thank you for taking the time to complete this form concerning your child's asthma needs. Please inform your school nurse if there are any changes to your child's asthma treatment plan during the school year.

SCHOOL ASTHMA EMERGENCY PLAN

*To be renewed annually at the beginning of each school year, and as needed during the school year.

Student's Name: _____Teacher/Grade: _____ School Year _____

TO BE COMPLETED BY PHYSICIAN

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

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Peak flow between _____ and _____
- ☐ Signs of increased work of breathing
- ☐ Other: _____
- ☐ Other: _____

STEPS TO TAKE DURING AN ASTHMA EPISODE:

1. Give emergency medication:

☐ **Rapid-acting Bronchodilator:**

Name of Medication: _____

Route/Dosage: ☐ MDI: _____ puff(s) **OR** ☐ Inhalation via nebulizer: _____ vial(s)

Additional Instructions: _____

☐ This med may be repeated _____ times, with each dose at least _____ minutes apart for severe breathing difficulty.

If both a nebulized inhalation and an MDI are prescribed/available for this student, is one particular format preferred over the other in particular circumstances?

☐ No, either is fine to use during acute exacerbations.

☐ Yes. Please specify: _____

☐ **Other medications/treatments:**

Name: _____

Route/Dosage: _____

Purpose: _____

When to use: _____

Additional Instructions: _____

2. Seek emergency medical care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Student exhibits:
  - ✓ Chest and neck pulled in with breathing
  - ✓ Flaring of nostrils
  - ✓ Trouble walking or talking
  - ✓ Hunched over while breathing
  - ✓ Struggling to breathe
  - ✓ Lips or fingernails turn gray or blue

Additional comments and special instructions: _____

_____

_____ _____ (_____) _____-_____

Physician Name/Signature *Date* *Phone Number*

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with Physician's instructions above. I have completed a Parent/Physician Request for Administration of Medication for each of the medications specified.

_____ _____

Parent/Guardian's Signature *Date*

2017-2018

HEALTH SERVICES
Richardson Independent School District

Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: _____ **School:** _____ **Teacher/Grade:** _____

Student's Name: _____ **Birth date:** _____/_____/_____

Medication: _____ **Exp. Date**_____ **Dosage:** _____

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered: _____ **Dates to be Administered:** _____

Condition for which medication is required: _____

Has your child ever taken this medication before? YES NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____

Special Instructions or known Side Effects of medication on your child: _____

_____

Please indicate how you would like the medication to be returned home:

☐ Send home in my child's backpack* ☐ Parent/Guardian will pick up med from clinic ☐ Do not return med, please discard any remaining doses

**Controlled substances (such as Ritalin, amphetamine salts, etc.) must be transported by a parent/guardian and will not be released to students.*

The district will take reasonable measures to store medication at ambient room temperatures unless refrigeration is required. Parents must take home medications during school breaks to avoid exposing medications to extreme heat or cold.

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed. I understand that for prescription medications, only a 30-day supply will be accepted at a time.

Parent/Guardian Signature: _____ **Email:** _____

Parent's Primary Phone: (_____)_____-_____ **Alternate Phone:** (_____)_____-_____

Physician's Name: _____ **Phone:** (_____)_____-_____

**A physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request. Medications with a printed pharmacy label for the student do NOT require the physician's signature below.*

***Physician's Signature:** _____

FOR OFFICE USE ONLY!

☐ Entered in Focus
☐ Teacher Notified ___/___

Prescription Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication returned to: Parent / Student _____ Date _____
Parent/Student Signature

HEALTH SERVICES
Richardson Independent School District

2017-2018

Parent/Physician Request for Self-Administration of Prescription Metered-Dose Inhaler (MDI)

*A separate request form is to be completed for each medication.

Date of Request: _____ School: _____School Year_____

Student's Name: _____ Teacher/Grade: _____

Medication: _____ Dosage: _____

Times to be Administered: _____ Dates to be Administered: _____

The purpose of the medication is: _____

Special Instructions/Precautions/Side Effects of medication on the above named student. _____

_____

_____

TO BE COMPLETED BY THE PHYSICIAN

My signature below indicates that:

1) The student indicated above has asthma.
2) I have instructed the student indicated above in the procedure to use his/her MDI and it is my professional opinion that this student is capable of carrying and self-administering the medication indicated above while on school property or at school-related events.
3) The student indicated above has my permission to self-administer the medication as directed above, in a properly labeled container, at the times and dosages as indicated above.

I understand that RISD reserves the right to require that this medication be kept in the clinic if in the school nurses judgement, the student cannot or will not carry the medication in a safe manner and properly self administer the medication.

I understand that the parent's signature in the box below gives permission for the appropriate school staff to contact me in order to obtain medical information/records

I also understand that my written request is valid for one school year and must be renewed at the beginning of each school year.

Physician's Name: _____ Signature: _____ Date: _____

TO BE COMPLETED BY THE PARENT

My signature below indicates that:

1) I give permission for my child to carry and self-administer the medication specified above on school property or at a school-related event or activity according to the physician's request and the RISD medication guidelines.
2) I give my permission for appropriate school staff to contact the physician indicated below to obtain medical information/records.

Parent/Guardian Signature: _____ E-Mail: _____

Parent/Guardian Home Phone: _____Work Phone: _____