Wylie ISD
.....building our future

Request for Asthma Information

Dear Parent,

Our records indicate that your child has asthma that may require treatment at school or a school related event. Attached to this letter are the following forms that will give Wylie ISD the necessary information and authorization to treat your child.

1. **Asthma Action Plan** - Must be updated and signed by the doctor and parent **every** school year. It includes Authorization for Self administration of Medication, and Authorization of Emergency Care.
2. **Administration of Medication Request Forms** (2) – One should be used for each medication sent to school. Includes permission to share information with Staff for the best possible care of your child.

Your child's supplies should include:

- Reliever inhaler with prescription label (please ask pharmacy to place label directly on inhaler).
- Spacing device, if available
- Nebulizer medicine and supplies, if necessary
- Peak flow meter, if you your child's Action Plan includes peak flow values that will help us assess your child's breathing.

According to State Law and Wylie ISD's policies your child may carry their inhaler while at school, if you and your child's physician sign and check the appropriate boxes on the Asthma Action Plan attached to this letter. Otherwise, all medications must be kept in the school clinic and used only under approved supervision.

Should you have any questions, please do not hesitate to contact the school nurse.

Sincerely,

Wylie ISD School Nurse
Phone:

<u>Please bring all supplies, wallet size photo of your child and this completed paperwork to the school nurse.</u>

REVISED: 10/17/2012

WYLIE

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

- All prescribed and over the counter medication must be in a container labeled by the pharmacist or prescriber for the named student.
- Non prescription or over the counter medications must be age/wt appropriate, in the original container (NO BAGGIES) with the label intact and the student's name clearly written.
- The medication may be administered by a designate of the principal.
- A separate permission form is required for each medication.
- No expired medications will be accepted or administered.
- Sample medication will be accepted only with written directions from the physician.
- All medication not picked up by the parent on or before the last day of school will be discarded.

Student Name: _____ DOB/Age: _____ Grade:_____ Teacher:_____

Medication: _____ Strength(mg): _____ Exp date: _____

Physician: _____ Prescription #: _____

Condition for which medication is to be administered: _____

Specific Instructions: _____

Route of Medication: ORAL TOPICAL INHALANT INJECTABLE OTHER _____

When to Administer: Dosage may not exceed recommended dose without written instructions.

_____ DAILY _____ ONE TIME DOSE _____ AS NEEDED (PRN)

Time to be given: _____ Dosage: _____ tab cap tsp tbsp puffs vial ml (circle one)

Administer this medication until: _____ end of school year OR _____ specific date ___/___/_____

I authorize, as needed, the sharing of information regarding my child's health between the school nurse, Wylie ISD faculty/staff and the prescribing health care provider to ensure his/her health and safety during school hours.

I give my consent for the above medication to be administered to the above named student by Wylie ISD school personnel. I release Wylie ISD and their employees from any liability in dispensing the above medications.

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

WYLIE

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I give my consent for the above medication to be administered to the above named student by Wylie ISD school personnel. I release Wylie ISD and their employees from any liability in dispensing the above medications.

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

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Wylie ISD Asthma Action Plan

BUS #_____Morning
BUS #_____Afternoon

Student Name: _____ DOB_____ Grade _____

The following to be completed by your PHYSICIAN:

1. Asthma severity (circle one): mild intermediate mild persistent moderate persistent severe persistent
2.

B. ROUTINE Medication Name	INH, ORAL, NEB?	Dosage or Number **of** Puffs Time of Day
1. _____	_____	_____
2. _____	_____	_____
C. BEFORE PE, EXERTION Medication Name	INH, ORAL, NEB?	Dosage or Number of Puffs
1. _____	_____	_____
2._____	_____	_____

3. **Immediate action is required when the above named student exhibits any of the following signs of an asthma attack!**

Repetitive cough Shortness of Breath Chest tightness Wheezing Chest Retractions

A. QUICK-RELIEF Medication Name	INH, ORAL, NEB?	Dosage or Number of Puffs
1. _____	_____	_____
2. _____	_____	_____

4. **Reassess in 10-15 minutes and reclassify the student according to the following parameters:**

	Cough	Respiratory Rate	Accessory muscle use or retractions	Labored breathing or SOB	Disposition
Normal	None to Occasional	2-4 y/o < 32 5-6 y/o < 28 7-14y/o < 25 >15 y/o < 22	None	Normal Easily speaks in sentences	-May return to Class -Report to parent
Symptoms Continue	Very frequent to constant	>Normal for age	Present	Speaks in short sentences, or only in words	Continue meds every 15 min until parents or EMS arrive
Medical Emergency	• No relief within 15 min of quick relief meds • Lips or fingernails are blue or gray • Is too short of breath to walk, talk, or eat		• Nasal flaring • Hunching to breathe • Neck pulling in with breathing		**Contact parents if unavailable activate EMS**

5. I certify that this child has a medical history of asthma and has been trained in the use of the listed medication, and is judged by me (initial)_____**capable**_____**not capable** of carrying and self-administering the listed medication.

_____ _____ _____
Physician signature Physician phone # Date

_____/_____ _____ _____
Parent/ Guardian signature Printed Parent phone # Date