*"We Inspire and Empower Learners"*

**NORTH ROYALTON CITY SCHOOLS**
6579 Royalton Road
North Royalton, Ohio 44133

# ASTHMA PACKET

Dear Parent/Guardian:

You have indicated that your child has asthma. Please complete the attached **SCHOOL ASTHMA RECORD and ASTHMA HEALTH CARE PLAN** and return them as soon as possible to the school's clinic. These must be completed in their entirety and signed by parent/guardian AND medical provider. The information will only be shared with the appropriate personnel such as your child's classroom teacher(s) and physical education teacher. This information that you and your medial provider provide will help to support the health and safety of your child.

If your student:

- Requires medication at school to be administered by school staff, please have an adult bring it to your student's school in original container provided by pharmacist, along with completed paperwork

- Requires medication AND is permitted to self-carry (and all of the forms have been completed and provided to school clinic), please provide a back-up inhaler for your student in the event he/she requires treatment but does not have medication available.

- Is no longer under the care of a physician for asthma, please handwrite a note and forward it to the school clinic as soon as possible. This will allow us to remove the medical alert from your child's record.

Please inform the school's clinic of any changes in your child's health condition or medication schedule should a change arise.

Thank you,

Carolyn Baetjer RN

Carolyn Baetjer, R.N., BSN, NCSN
District Health Coordinator
North Royalton City Schools
14709 Ridge Road
North Royalton, Ohio 44133
440.582.9067

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# SCHOOL ASTHMA RECORD

**(To be completed by Parent/Guardian)**

Child's Name _____ Date _____

Parent/Guardians(s) Name _____

Address _____ Home Phone _____

City _____ Alternate Phone _____

Physician Treating Child's Asthma _____

Physician's Phone _____

1. When was your child diagnosed with asthma?

2. Has your child ever been hospitalized for an asthma-related illness? If yes, when?

3. Approximately how often does your child have a severe acute asthma episode?

4. Briefly describe what triggers your child's asthma symptoms. Allergens? Exercise?

5. Are there any sports that are restricted from your child's plan of care? If yes, list.

6. Do certain weather conditions affect your child's asthma? If yes, please list.

7. List all medications that your child takes routinely including dosages, frequency, & side effects.

8. Does your child understand asthma and what to do to manage it?

9. How do you want the school to treat an episode of asthma if it should occur?

10. If the child does not respond to the treatment at school, what action should the school take?

Parent/Guardian Signature _____ Date _____

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# NORTH ROYALTON CITY SCHOOLS
# ASTHMA HEALTH CARE PLAN
# * CONFIDENTIAL *

☐ Addendum Attached

_____ _____
Received by Date

**This form is intended to be used as an addendum to a Section 504 plan, if necessary, or for those students who need asthma-related support in the school environment but are not eligible under Section 504. Use of this form for 504-eligible students does not eliminate the need for a 504 plan (DSE-504D).**

**Student Information**

Name of Student: _____ Grade _____

Date of Birth _____Physical Education Days and Times _____

**Emergency Information**

Parent/Guardian(s) Names _____

Home/Cell Phone _____ Alternate Phone _____

Physician's Name _____ Physician's Phone _____

In case of an emergency, contact:

1. Name _____Phone _____

2. Name _____Phone _____

3. Name _____Phone _____

What triggers student's asthma attack? (Check all that apply)

☐ Illness ☐ Cigarette or other smoke ☐ Food: _____
☐ Emotions ☐ Exercise/Physical Activity ☐ Weather Changes
☐ Chemicals ☐ Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Pollen
☐ Other:_____

Describe the symptom(s) your child experiences before or during an asthma episode:

☐ Cough ☐ Tightness in Chest ☐ Rubbing chin/neck ☐ Wheezing
☐ Runny Nose ☐ Breathing hard/fast ☐ Shortness of breath ☐ Tired/Weak
☐ Other

**<u>Does student take *daily* medication for asthma? If so, list preventative medication(s) and dosages:</u>**

_____

_____

| Student Name | Date of Birth |
|---|---|
| | |

## TO BE COMPLETED BY HEALTH CARE PROVIDER:

The child's asthma is: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent
☐ Severe Persistent ☐ Exercise-Induced

**Restrictions (if any):**_____

**Steps for an Acute Asthma Episode (per physician):**

_____

_____

**Medication to be given at school (if any):**

Name of Medication/Inhaler:_____
Dose:_____
Frequency:_____
Date to begin administration_____Date to end administration_____

**Patient/Student Instructions:**
☐ Student shall **NOT** be able to carry his/her inhaler
☐ Student needs supervision or assistance to use his/her inhaler
☐ Student has been instructed in the proper use of all his/her asthma inhaler, and in my opinion, the student can carry and use his/her inhaler at school
☐ Student is to notify his/her designated school clinic personnel after using inhaler

**Possible adverse reaction(s) to student:**_____

**Possible adverse reaction(s) for UNauthorized user:**_____

**Procedure to follow in the event medication does not produce expected relief from student's asthma attack:**_____

As the prescriber, I have determined that this student is capable of possessing and using asthma inhaler appropriately and I have provided the student with training in the proper use of prescribed asthma inhaler.

_____ _____
HEALTH CARE PROVIDER SIGNATURE DATE

_____ _____
HEALTH CARE PROVIDER PRINTED NAME PHONE

I, as parent/guardian of this student, give permission for school personnel to follow this plan, administer medication (if any) and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Health Care Plan for my child. I also consent to the release of the information contained in this Asthma Health Care Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____
Parent/Guardian's Signature/Printed Date