

Mansfield R-IV School
415 W. Ohio St.
Mansfield, MO. 65704
417-924-3289

ASTHMA MEDICATION SELF-ADMINISTRATION FORM

Student Name _____ Date of Birth _____ Grade _____

The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer life-saving asthma medications when the following criteria are met:

- 1) *Written authorization by the parent/guardian*
- 2) *Medical history of student's asthma on file at the school*
- 3) *Written asthma action plan/individual healthcare plan on file at school*
- 4) *Written authorization from the prescribing health care provider that child has asthma, has been trained in the use of the medication and is capable of self-administration of the medication*

MEDICATION NAME _____ Dose _____ Time or Interval _____

Route/inhalation device _____ Instructions _____

MEDICATION NAME _____ Dose _____ Time or Interval _____

Route/inhalation device _____ Instructions _____

ALLERGIES: list known allergies to medications, foods, or air-borne substances _____

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms for 3 or more hours.

Signature of parent or legal guardian _____ Date _____

Parent/Guardian:

Name: _____ Home Phone _____

Address: _____ Work Phone _____

Name: _____ Home Phone _____

Address: _____ Work Phone _____

Emergency Contacts:

Name: _____ Home Phone _____

Work Phone _____

I, a licensed health care provider, certify that this child has a medical history of asthma, has been trained in the use of the listed medication, and is judged to be capable of carrying and self administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms for at least 3 hours.

Signature of health care provider _____ Date _____

Healthcare Provider: Name: _____

Fax: _____ Phone: _____

Address _____ City: _____ Zip: _____

SCHOOL ASTHMA HISTORY AND NEEDS ASSESSMENT

Student Name _____ Date of Birth _____ Grade _____

How long has your child had asthma? _____

What signs and symptoms signal a flare up of your child's asthma _____

What do you do at home to manage asthma flare ups? _____

Child's personal Best Peak Flow number is _____

Green Zone (80% to 100% Personal Best) _____

Yellow Zone (50% - 80% Personal Best) _____

Red Zone (Below 50% Personal Best) _____

How many times has your child been taken to an ER due to asthma? _____ When? _____

How many times has your child been placed in the hospital due to asthma? _____ When? _____

How many days of school did your child miss due to asthma last year? _____

Describe any special care your child requires at school _____

Describe the plan of care in the event of field trips, after-school activities, and exercise _____

Equipment and Supplies _____ Daily Asthma Medications
Provided by Parents _____ Emergency Asthma Medications
_____ Peak Flow Meter Supplies (include mouthpiece)
_____ Spacer for Meter Dose Inhaler Use

Please, list asthma and allergy medications.

I rate my child's need for additional knowledge about asthma as:

1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my child's need to improve skills for self-management of asthma (use of inhalers, peak flow meters, symptom reporting) as:

1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my child's health problems related to asthma currently as

1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my level of concern about asthma posing safety risk for my child at school:

1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my need for additional information about asthma as:

1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

Asthma Needs Score= _____ (sum of item scores)

Person interviewed _____ Date _____

Signature of school nurse _____ Date _____

