WARREN COUNTY PUBLIC SCHOOLS HEALTH SERVICES

Primary Care Provider Authorization: Asthma (Side One)

Student:_____ Date of Birth:_____

School:_____ Grade_____ School Year:_____

Triggers (Check all that apply to this child)

- ❑ Exercise
- ❑ Strong Odors
- ❑ Chalk Dust
- ❑ Foods (Specify)
- ❑ Animals
- ❑ Pollen
- ❑ Change in temperature
- ❑ Fumes
- ❑ Molds
- ❑ Carpet
- ❑ Respiratory Infection
- ❑ Trees/Grass/Shrubbery

*If food(s) may cause an anaphylactic reaction, **you MUST complete a Primary Care Authorization Allergic Reactions/Food Allergies/Anaphylaxis/EpiPen/Twinject form**

❑ Other (Specify):_____

Signs and Symptoms student will likely exhibit (Check all that apply)
***Note: Parent/Guardian will be contacted if symptoms persist**

❑ Coughing ❑ Wheezing ❑ Labored/Difficulty Breathing

❑ Other (Specify):_____

Recommended Preventative/Interventive Measures (Check all that apply)

- ❑ Encourage student to assume position of comfort
- ❑ Nebulizer **(see back of form)**
- ❑ Inhaler **(see back of form)**
- ❑ Other (Specify):_____
- ❑ Offer warm liquid to drink
- ❑ Encourage slow, even breaths

PEAK FLOW MEASUREMENTS

Will this child be checking his/her peak flow measurements at school? ❑Yes ❑No
***IF YES, PLEASE ATTACH LEVELS AND INTERVENTIONS NEEDED**

EMERGENCY PLAN OF ACTION

1. Initiate preventative/intervention measures as indicated on this form.
2. Call EMS 911 if: wheezing or coughing does not improve after #1 completed; student is hunched over and//or having difficulty breathing; student has trouble walking or talking; student's fingernails or lips are blue/ashen; and/or student's peak flow readings drop into the "red" zone.
3. Notify school personnel trained in CPR/first aid to come stay with student and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian or emergency contact.
5. If student needs to be transported via EMS, Warren County Public School staff must ride with student unless parent and/or emergency contact accompanies them.
6. Other:_____
7. Other:_____

Revised April 2011

PLEASE COMPLETE BOTH SIDES OF THIS FORM

WARREN COUNTY PUBLIC SCHOOLS HEALTH SERVICES

Primary Care Provider Authorization: Asthma (Side Two)

Student:_____ Date of Birth:_____

School:_____ Grade_____ School Year:_____

INHALERS:

This student has been trained to use his/her inhaler and should be allowed to carry and use their prescription inhaler on his/her own. ❑Yes* ❑No**

*If yes, please note: **Student will be expected to carry and use his/her inhaler responsibly.**

If NO, where should inhaler be **kept:

❑ In office ❑ In classroom ❑ Other:_____

Date to begin medication(s):_____ Date to discontinue medication:_____

Name of inhaler and dosage:_____

Time of day to administer:_____

Reaction or side effects:_____

Comments:_____

NEBULIZER INHALATION THERAPY

Medication via the nebulizer will be given at school as follows: ❑ On a daily basis ❑ As needed

Date to begin medication(s):_____ Date to discontinue medication:_____

Medication No. 1 (Name and Dosage):_____

Medication No. 2 (Name and Dosage):_____

Time of day to administer:_____

Reaction or Side effects:_____

Comments:_____

FORM MUST BE COMPLETED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN

_____ _____

Printed Name of MD, ARNP Address

_____ _____ _____

Signature of MD, ARNP Telephone No. Date

*Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed WCPS personnel. **By signing this form, the parent/guardian shall acknowledge that the Warren County Board of Education and its employees shall incur no liability as a result of any injury sustained by the student from self-administration of his/her medications to treat asthma and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the self-administration of such medication. This form shall not relieve the liability of the school or its employees for their own negligence.**

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

_____ _____ _____

Emergency Contact Telephone No. Relationship

PLEASE COMPLTE BOTH SIDES OF THIS FORM

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