ASTHMA SCHOOL FORM
SANTA CRUZ COUNTY SCHOOLS

Student Name: ____ **DOB:** __________________

Diagnosis: __________________________________ **Parent Phone:** ____________________

Triggers: ____

MEDICATIONS TO BE GIVEN AT SCHOOL

If peak flow available: use inhaler if ____________________

Quick Relief Inhaler: ________________________________

☐Use with spacer

______puffs every________ hours as needed for cough, wheezing, or shortness of breath.

☐ Use 5-10 minutes before exercise

☐ Repeat if not improved in _____ minutes

Other Medications:________________________________

☐Student to **carry medication and self-administer** and

- This health care provider has confirmed that the student is capable of appropriate self-administration of the above medication, **and,**
- If student is younger than 18, the parent/guardian assumes all liability related to this student's use, timing and technique in self-administering this medication.

MEDICAL ALERT***

- Rapid breathing
- Not having enough breath to speak
- Persistent cough or wheeze.
- Decreased level of consciousness.
- Flared nostrils, tight neck muscles, sitting hunched forward.

***** Call parent +/or 9-1-1 if these symptoms are present.**

CLINIC/PROVIDER STAMP

FOR SCHOOL USE:

Expiration date of inhaler: ________________________ (use pencil)

□ School to store medication in __________________________

□ Notify parent/guardian with time inhaler used for quick relief.

Call parent/guardian if not improved after above treatment.

My signature below provides authorization for the above orders.

All procedures will be accordance with state laws and regulation. This authorization is valid for one year.

Health Care Provider Signature: ____ **Date**: __________________

<u>Parental Consent for Asthma Management in School / El Consentimiento de los Padres para el manejo del asma en la escuela</u>

As the parent or guardian of the above named student, I request that the school assist with the above medication as directed above and in accordance with all state laws and regulations. The school nurse may communicate with the above health care provider about this student when necessary. (Ed Code section 49423 and 49480). Como el padre o guardián del estudiante arriba mencionado, solicito que la escuela ayudar con la medicación como se indica anteriormente y de conformidad con todas las leyes y reglamentaciones estatales. La enfermera de la escuela podrá comunicarse con el anterior proveedor de atención médica acerca de este estudiante cuando sea necesario. (Código de Educación sección 49423 y 49480).

Parents/ Guardians must/ Los Padres/Tutores deben:

- Provide the necessary equipment (inhaler, spacer, etc.). The inhaler should be in the original packaging/Proporcionar el equipo necesario (inhalador, ditanciador, etc.). El inhalador debe estar en el embalaje original.
- Notify the school of any changes in student's health or medication plan/Notificar a la escuela de cualquier cambio en la salud del estudiante o plan de medicamento.
- Notify the school immediately of any change in health care provider authorization/Notifique a la escuela inmediatamente de cualquier cambio en la autorización medica.

Parent /Guardian Name:____________________________**Signature:**____________________________________ **Date:**______________

Nombre de los Padres/Tutores **Firma** **Fecha**

Student Contract for Carrying Own Medication: I, ____________________________will be responsible for carrying, administering, and keeping safe at all time, my asthma medication. I will use the asthma medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing.