CHRISTINA SCHOOL DISTRICT
Educating each student to succeed
www.christinak12.org

Dear Parent/Guardian of: _____ **Date:** _____

You have told us on your student's Registration Form or it has been noted in his/her School Health Record that your student has asthma. Please fill out the information located below and return it as soon as possible. The information will be shared with the appropriate personnel such as your student's classroom teacher(s) and the specialists. This information will help them work with your student to minimize unnecessary restriction, feeling of being treated differently, and possible absenteeism.

PLEASE BRING ANY PRESCRIBED MEDICATION TO THE NURSES OFFICE, AS WELL AS AN ASTHMA ACTION PLAN FROM YOUR HEALTH CARE PROVIDER. Please call the school nurse with any questions at 302-454-2357 Ext: 105.

Sincerely,

Kathleen M. Luna, BSN, RN

Questionnaire for Parents of Students with Asthma

Is it recommended the student keep an inhaler in the nurses' office for treatment of asthmatic episodes?

Yes____ No_____

IF NOT NEEDED, EXPLAIN WHY: _____

Does your student use a nebulizer treatment? Yes____ No ____

Does your student use an inhaler? Yes____ No____

Medication being sent to school: _____

Does your student have an Asthma Action Plan? Yes____ **(Please send it to school)** No____ **(Please ask your doctor to complete)**

Circle symptoms your child has during an asthma attack: Wheeze Chest Pain Tightness Cough Other

Does your student take any medications routinely prior to exercise to prevent an asthma attack (i.e. gym/recess) Yes____ No____ **If yes, please indicate medications:** _____

Comments:

Signature of Parent/Guardian_____ Date_____

AMERICAN LUNG ASSOCIATION.

Asthma Action Plan

General Information: **DOB**____ / ____ / _____

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/Health Care Provider _____ Phone numbers _____
- Physician Signature _____ Date _____

Severity Classification

○ Mild Intermittent ○ Moderate Persistent
○ Mild Persistent ○ Severe Persistent

Triggers

○ Colds ○ Smoke ○ Weather
○ Exercise ○ Dust ○ Air pollution
○ Animals ○ Food
○ Other _____

Exercise

1. Pre-medication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter
More than 80% of personal best or _____

Control Medications

Medicine	How Much to Take	When To Take It

* Both the Healthcare Provider and the Parent/Guardian see that the child has demonstrated the skills to carry and self-administer their quick relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter
Between 50 to 80% of personal best or
_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take it

IF your symptoms (and peak flow, is used) return to Green Zone after one hour of the quick relief treatment, THEN

- ○ Take quick-relief medication every 4 hours for 1 to 2 days
- ○ Change your long-term control medicines by _____
- ○ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ○ Take quick-relief treatment again
- ○ Change your long-term control medicines by _____
- ○ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better

Peak Flow Meter
Between 0 to 50% of personal best or
_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Go to the hospital or call for an ambulance if

- ○ Still in the red zone after 15 minutes
- ○ If you have not been able to reach your physician/health care provider for help
- ○ _____

Call an ambulance immediately if the following danger signs are present

- ○ Trouble walking/talking due to shortness of breath
- ○ Lips or fingernails are blue

CHRISTINA
SCHOOL DISTRICT

RELEASE FORM

Student Possession and Use of Asthmatic Quick Relief Inhaler

(in accordance with 14 DE Admin. Code 612 and 817)

I am the parent/legal guardian of _____ ("Student"). Attached is a copy of the so named Student's prescription to possess and use a quick relief inhaler.

I authorize the so named Student to possess and use the quick relief inhaler in school and on field trips without supervision of the school nurse, or any other employee.

I release the District, the Board of Education, and District employees from any and all liability arising out of the Student's possession and use of the quick relief inhaler in school, or during any school activity.

_____ _____

Parent/Legal Guardian Date

_____ _____

Student Date

_____ _____

School Nurse Date

CHRISTINA SCHOOL DISTRICT

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Parental Request to Have Prescription Medication/Treatment

Administered in School

If it is necessary for your child to receive medication during the school day, please do the following:

- Send the medication to school with a responsible adult if you are unable to take it to school
- Send the medication in the original container properly labeled with correct name, time, dose and date
- Count the tablets (unless the number of tablets is the exact number on the

Date_____

Student's Name_____

Medication_____Dose_____Time_____

Reason for medication_____

Allergies to any medications_____

Number of tablets/liquid/MDI/nebs sent _____

I am aware that the school nurse may have the need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and I give my permission.

By signing below, I give permission for my child to be given medication at school by the school nurse and I also give permission for my child to be assisted with medication by his/her teacher while on field trips for the current school year.

PARENT/GUARDIAN Signature_____Date_____

NURSE Signature_____Date_____

The Christina School District is an equal opportunity employer. It does not discriminate on the basis of race, color, religion, national origin, sex, sexual orientation, marital status, disability, age or Vietnam Era veteran's status in employment or its programs and activities