Humble Independent School District Health Services

Physician's Documentation

ASTHMA

Student Name: _____ **DOB:** _____

ID#: _____ Grade: _____ Teacher: _____

Parent/Guardian Name: _____

Best Contact #: _____ Alternate Contact #: _____

Student has the following triggers which cause asthma episodes (check all that apply)

- ☐ Exercise
- ☐ Respiratory infection
- ☐ Change in Temperature
- ☐ Animals_____
- ☐ Foods_____
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Pollens
- ☐ Molds
- ☐ Other

Comments:_____

Daily **Home** Medication:

Name	Dose	Time	Frequency
1.			
2.			

SCHOOL ACTION PLAN:

NOTE: Administration of Medication form must also be competed in addition to this form

Emergency action is necessary when the student has symptoms of _____
or has a peak flow reading of below _____.

Steps to take during an asthma episode:

- ☐ Administer inhaler→Medication name:_____ Dose:_____
- ☐ Repeat inhaled medication in: _____ minutes_____ times
- ☐ Give nebulizer treatment→Medication name:_____ Dose:_____
- ☐ Call parent and "911" if no improvement.

State law allows a student to carry an asthma device if the following criteria are followed.
The parent of the student provides to the school:

a. Written authorization for the student to self-administer the prescription medicine while on school property or at a school-related event or activity; and
b. A written statement, signed by the student's physician or other licensed health care provider that states:
   - That the student has asthma or anaphylaxis and is capable of self-administering the medicine;
   - The name and purpose of the medicine;
   - The prescribed dosage for the medicine;
   - The times at which or circumstances under which the medicine may be administered; and
   - The period for which the medicine is prescribed. The physician's statement must be kept on file with the school nurse

Physician initials in box indicate the following:

☐ I have instructed the above named student in the proper use of his/her asthma device.
It is my professional opinion that he/she should be **allowed to carry and self-administer the asthma device** as needed.

After use the student should report to the clinic. Students with permission to carry respiratory inhalers are encouraged to have a backup inhaler in the clinic. Students using a respiratory inhaler outside the clinic must report the use to the staff member responsible for the setting/activity, and the nurse.

Physician Name_____ **Physician Signature**_____ **Date**_____

Parent Name_____ Parent Signature_____ Date_____

School Nurse Signature_____ Date _____

Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
_____

Guidelines for acceptance and administration of medications in Humble ISD are available from the campus nurse.

Students Name_____ **DOB**_____
Last **First** **MI**

PARENT/GUARDIAN SECTION

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Note: Non-prescription medications taken more than 4 times in a month and prescription PRN medication will require a physician's order (signature is required) indicating maximum dosage allowed per month.

PARENT: PLEASE SIGN AT THE BOTTOM OF THE MEDICATION FORM

PHYSICIAN'S SECTION: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Parent approval for release of information indicated below. Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or in excess of recommended dosage on the container and all prescription PRN medications require a physician's order.

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Physician's name (print)_____ **Physician's signature**_____

Phone number_____ **Fax number**_____ **Date**_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication.
Completion of this form acknowledges your review of and agreement to follow all district medication guidelines.

Parent's Signature _____ **Date**_____
Daytime Phone_____ Alternate phone _____

Humble Independent School District Health Services

Asthma Health History

Student Name: _____

Student ID: _____ Date of Birth: _____

Parent/Guardian: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

1. **Does your child have a diagnosis of asthma from a healthcare provider:** ☐ **No** ☐ **Yes**
   Managing physician: _____ Phone: _____

2. **History of Current Status:**

a. What are your child's triggers:

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Odors/Fumes
- ☐ Vapors _____
- ☐ Other: _____
- ☐ Foods _____
- ☐ Animals _____
- ☐ Dust
- ☐ Mold
- ☐ Pollen

b. Age of student when asthma first diagnosed: _____

c. Date of last asthma episode: _____

c. How often does your child use his/her **rescue** inhaler:
☐ Rarely ☐ Occasionally ☐ Monthly ☐ Weekly
☐ My child does not have a/has not been prescribed a rescue inhaler

d. Symptoms: _____

e. Ever hospitalized due to asthma: ☐ Yes ☐ No
If yes, explain: _____

f. Are the number of episodes: ☐Same ☐Better ☐Worse

3. **Trigger and Symptoms:**
   a. What are the early signs and symptoms of your student's asthma episode? *(Be specific; include things the student might say)* _____
   b. How does your child communicate his/her symptoms? _____
   c. How quickly do symptoms appear after trigger? Within: _____ secs _____ mins _____ hrs _____ days
   d. Please check the symptoms your child has experienced in the past:

General	Abdominal	Throat	Lungs	Heart
☐ Trouble Sleeping caused by coughing, SOB, Wheezing	☐ Nausea	☐ Itching	☐ Shortness of breath	☐ Increase pulse
☐ Frequent Respiratory Infections	☐ Vomiting	☐ Tightness	☐ Repetitive Cough	☐ Loss of Consciousness
☐ Delayed recovery of Bronchitis episodes		☐ Frequent Intermittent Cough	☐ Whistling or Wheezing when exhaling	☐ Chest pain
☐ Limited exercised because of Shortness of Breath		☐ Frequent cough	☐ Chest Congestion	
☐ Fatigue			☐ Chest Tightness	

4. **Treatment:**
   a. How is asthma being treated? _____
   b. What medication is the student taking (both daily and rescue)? _____
   c. How effective is the student's response to treatment? _____
   d. Has there ever been an emergency room visit? ☐ No ☐ Yes, explain: _____
   e. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____
   f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes
   g. Have you used the treatment or medication? ☐ No ☐ Yes
   h. Please describe any side effects or problems your child had in using the suggested treatment: _____

5. Self Care:

a. Is your student able to recognize and monitor their asthma symptoms? ☐ No ☐ Yes

b. Does your student:

1. Know what triggers to avoid……..... ☐ No ☐ Yes
2. Communicate asthma symptoms……..... ☐ No ☐ Yes
3. Tell an adult immediately when symptoms occur……. ☐ No ☐ Yes
4. Wear a medical alert bracelet, necklace, watchband…….. ☐ No ☐ Yes
5. Tell peers and adults about their asthma…….☐ No ☐ Yes

c. Does your student know how to use their emergency medication? ☐ No ☐ Yes

d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family/Home

a. How do you feel that the whole family is coping with your student's asthma? _____

b. Does your child carry a rescue inhaler in the event of an asthma episode? ☐ No ☐ Yes

c. Has your child ever had to use a rescue inhaler? ☐ No ☐ Yes

d. Do you feel that your child needs assistance in coping with his/her asthma? ☐ No ☐ Yes

7. General Health:

a. How is your child's general health other than having asthma? _____

b. Does your child have other health conditions? _____

c. Please add anything else you would like the school to know about your child's health: _____

_____

8. Notes:

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Campus:** _____ **Date:** _____

Humble Independent School District Health Services

Authorization for Release of Medical Records

Student_____ DOB_____ Date_____

Campus_____ Grade_____

I grant permission for the release of medical information and physician recommendations as it pertains to the student's accommodations which will allow for participation in the educational process with minimal disruption.

Information requested_____

_____

_____

From: (Physician Name & Address)

_____

_____

_____

_____

To: (School Nurse)

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian, (Student if 18 years or older)

Date

The mission of Humble ISD Health Services is to enhance the health and well being of the students, staff, and community thus supporting the education of all students through maximizing their educational time.