School District of Monticello

Consent for Inhaled Asthma Medications

Student _____ Grade _____

To be completed by Health Care Provider:

Medication/Rescue inhaler _____ Dose _____

Frequency _____

Diagnosis _____

Side effects _____

Comments _____

Is the child knowledgeable about his or her asthma medication? ❑ Yes ❑ No
Has the child demonstrated the proper technique in administering medication? ❑ Yes ❑ No
It is my professional opinion that this student may carry and use this inhaled medication independently. ❑ Yes ❑ No

Provider signature _____

Date _____ Phone number _____

To be completed by parent/guardian:

I give my child permission to carry and self-administer inhaled asthma medication. I believe he/she is responsible to keep this medication in his/her possession and control its use. ❑ Yes ❑ No

I authorize trained staff to administer and/or assist my child in taking this medication at school and to communicate with the healthcare provider, if necessary. I authorize the release of this information to appropriate school personnel and classroom teachers.

Parent/Guardian signature _____

Date _____ Phone number _____

*PLEASE COMPLETE ASTHMA MANAGEMENT PLAN ON BACK OF THIS PAGE.

Asthma Management Plan

Student _____ Grade _____

Check triggers of an asthma episode for your child:

- ❑ Exercise
- ❑ Respiratory Infection
- ❑ Change in temperature
- ❑ Other_____
- ❑ Food Allergies _____
- ❑ Strong odors or fumes
- ❑ Molds
- ❑ Pollens
- ❑ Animals

List any control measures, pre-medication and/or dietary restrictions that the student needs to prevent an asthma episode.

_____

_____

Directions for school staff responding to an asthma episode:

If you see this:	Do this:
• Wheezing, noisy breathing, or whistling sounds in the chest • Coughing for prolonged periods of time • Difficulty catching breath • Chest tightness • Stopping activity • Breathing hard and fast • Can only speak in short sentences	• Remove student from trigger- stop activity, remove from area of allergen • Have student sit, but do not have student lie down • Administer/help student use rescue inhaler as ordered • Obverse student to ensure symptoms are improving
• If in 15 minutes, symptoms persist or are getting worse at any point	• Call Carolyn, RN (2736) • If Carolyn is not at school, call parents/guardians/emergency contact • If unable to contact any of the above and student continues to be symptomatic, call 911
• If at any point: ▪ Student is blue or grey around lips or in nail beds ▪ Unable to speak at all do to shortness of breath ▪ You feel student is severely struggling to breath	• Call 911 and parents • Assist student to use rescue inhaler • Do not move student

I give my permission to school personnel to implement the above management plan.

Parent/guardian signature _____ Date _____

School nurse signature _____ Date _____