ASTHMA INFORMATION SHEET

Student's Name: _____ Grade: _____ Teacher:_____
Parent/Guardian's Name: _____
Home Phone #: _____ work/cell phone # _____
Emergency Contact: _____ Phone # _____
Doctor's Name: _____ Phone # _____

When was the student's last asthma attack? _____

How often does the student have asthma attacks? _____

What Triggers the student's asthma attacks (e.g. allergies, exercise, etc.)? _____
_____
_____

Describe the student's asthma attacks – Do they wheeze? Do they cough? Do they become short of breath? Do they complain of chest pain? _____
_____
_____

Asthma medications the student uses (if any):

Name Dosage

Frequency

_____
_____
_____

Medication side effects: _____

What is student's current best peak flow if know?_____

Treatment Instructions for the School Nurse: _____
_____
_____
_____

_____ _____

Parent Signature Date

KLEIN INDEPENDENT SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

STUDENT:_____ DATE OF BIRTH:_____

In an effort to promote student health and maintain school performance, it is necessary that medication be given during school hours.

Physician's request for giving medication(s) during school hours:

NAME OF MEDICATION	DAILY DOSAGE	SCHOOL DOSAGE	TIME TO BE GIVEN
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Comments: (Reason for medication, possible side effects, etc.)

_____

_____

*No injections may be given except those needed in emergency situations or those necessary for the student to remain in school (i.e. insulin, epinephrine).

Physician's Signature: _____ Date: _____

Physician's Name (**Please Print**): _____Phone: _____

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Klein school personnel are not permitted to give medication of any kind, including aspirin, similar preparations, or any other drugs, unless the parent requests in writing that there is a need for such medication. Non-prescription medications needed for longer than two weeks must also have a written request from a physician. When administering prescription medicines, the school district would prefer to have a written statement from a physician or dentist licensed to practice in the United States. Information, however, placed on a prescription label, if it is precise and clear to the school nurse, may be substituted for the above noted statement. The prescription must be filled by a pharmacist licensed to practice in the United States. All medications must be in their original container and kept in locked storage in the office of the nurse or principal's designee and administered by the nursing staff or a school employee. If the circumstances are questionable, the school employee reserves the right to deny the parent's request. No vitamins, health food or herbal preparations will be given by any school employee. Neither prescriptions nor over the counter medications from foreign countries will be administered.

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PARENT/GUARDIAN AUTHORIZATION

I hereby authorize school personnel to administer non-prescription medication to my child during school hours or prescription medication as prescribed by the physician. I understand that any non-prescription medication that is to be dispensed to my child longer than two weeks will also need a doctor's authorization. Also, I am aware that no medication dosage will be changed without an order from the prescribing physician.

*I **(do / do not)** authorize school personnel, at my oral request, to administer dosages of medication in addition to the dosages specified on this form, if necessary for my child to receive the daily dosage prescribed by his or her doctor and specified on this form. If I make such a request, I shall ensure that I provide the school with additional medication thereafter to enable the school to continue making the scheduled school dosages*

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: _____

Item No. 19.5550
Revised 1/26/95, atty.
Updated 8/28/01 atty.

ASTHMA ACTION PLAN

Name: _____ **Birthdate:** _____

Student ID: _____ **Grade:** _____ **Campus:** _____

KLEIN ISD
FUTURE READY

TO BE COMPLETED BY HEALTH CARE PROVIDER

MEDICATION: _____

DOSAGE: _____

SIDE EFFECTS: _____

ADMINSTRATION

☐ With Spacer
☐ As Needed Every _____ Hours
☐ 15 minutes prior to exercise if needed

GREEN ZONE	YELLOW ZONE	RED ZONE
Breathing is good No cough or wheeze Can work and play	Some problems breathing Cough, wheeze or chest tight Problems playing	Audible wheezing, Can't talk well Breathing hard and fast Nasal flaring
Follow regular medication plan	Give _____ puffs of inhaler _____ minutes apart. Monitor student to check for zone change.	Follow **EMERGENCY PLAN**

EMERGENCY PLAN - when the student exhibits symptoms from the RED ZONE:

- Give _____ puffs of inhaler or 1 nebulized treatment.
- If no improvement, treatment can be repeated _____ times _____ minutes apart.
- **If no improvement after a total of _____treatments call 911 and notify parent.**

☐ The inhaler must be kept in the school clinic. Student is not allowed to carry inhaler with them.

☐ This student has been educated and is knowledgeable about asthma and can properly self-administer the prescribed medication. He/ She has been instructed in the proper handling and carrying of the inhaler and that it must be kept out of the reach of other students at all times. He/ She are aware the inhaler must have a current prescription label indicating that it has been prescribed for them. Please allow him/her to carry the inhaler with them while on school property or at school related events.

_____ _____ _____
Health Care Provider Signature Printed Name Date

Tel #:_____ Fax #:_____

TO BE COMPLETED BY PARENT

I do ☐ / do not ☐ authorize school personnel to administer the prescribed medication to my child as prescribed by the Health Care Provider.

Parent's Signature: _____ Printed name: _____

Date: _____ Emergency phone numbers: _____

Clear all fields

KLEIN INDEPENDENT SCHOOL DISTRICT
NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name: DOB: School:

We are requesting that you authorize Klein ISD (or its agent) to speak with the party specified regarding the above-named student and the release or request of specified records containing confidential information regarding the above-named student.

☐ KLEIN I.S.D. HAS PERMISSION TO RELEASE INFORMATION TO:

Name: Phone:

Address:

City: State: Zip:

☐ KLEIN I.S.D. HAS PERMISSION TO REQUEST INFORMATION FROM:

Name: Phone:

Address:

City: State: Zip:

RECORDS REQUESTED
- ☐ All Educational Records
- ☐ Transcript & Immunizations
- ☐ Academic Assessments
- ☐ Psychological Assessment
- ☐ Comprehensive Assessment
- ☐ Speech/Language Assessment
- ☐ Vocational Assessment
- ☐ OT/PT Assessments
- ☐ Medical Reports
- ☐ ARD/EP Reports
- ☐ Individual Translation Plans
- ☐ Other: _____

PURPOSE OF DISCLOSURE:
☐ Health Planning ☐ Educational Planning ☐ Student Transfer ☐ Other:

If you wish to have more information or if you have any questions, please contact the following staff person:

Name: Phone:

__Yes __No I have been fully informed and understand the school's request for release of the student's records as described above. This information will be released upon receipt of my written request.

__Yes __No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of the signature.

Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of the child or the provisions of a free appropriate public education.

_____ Date: _____
Signature of Parent, Guardian, Surrogate Parent, or Adult Student

_____ Date: _____
Signature of Interpreter, if used

Please return to: Name Date Mailed/Sent: Address
City/State/Zip