Parent Consent and Authorized Healthcare Provider Authorization for Management of
Moderate to Severe Persistent or Poorly Controlled Asthma at School and School-sponsored Events

Pupil:	**DOB:**	**Date:**
School:	**Teacher/Rm:**	**Grade:**
Medical office:	**Patient Identification #:**	

1. Asthma Action Plan attached: ☐ Yes ☐ No

2. Monitoring at school:

☐ Observation and/or pupil report of symptoms

☐ Peak flow meter and symptoms

Measure peak flow when: _____

Personal best peak flow: _____

☐ Monitor peak flow on regular schedule:
Times: _____

3. Asthma symptoms are triggered by:

☐ Exercise
☐ Respiratory infection
☐ Cold weather
☐ Sudden temperature change
☐ Air pollution
☐ Perfumes
☐ Pollens: ☐ grasses ☐trees ☐shrubs/flowers
☐ Animal dander/feathers
☐ Dust mites
☐ Cockroaches
☐ Molds
☐ Smoke
☐ Strong odors/fumes: _____
☐ Food: _____

4. Medications to be taken at school:
(Please complete attached medication authorization forms.)

☐ Quick-relief medication:_____

Route:☐ Inhaler ☐ Inhaler+spacer ☐ Inhaler+spacer+ mask
☐ Nebulizer (requires unit-dose vials);
Monitor pulse & respirations: ☐ No ☐ Yes

☐ Quick-relief medication specified above to prevent EIA
_____ min. before exertion

☐ Emergency medication: _____

Route: _____ Administer when: _____

☐ Other medication: _____

5. Actions when symptoms occur at school:

☐ Check peak flow reading unless pupil in severe distress

☐ Administer quick-relief medication:
Medication: _____

Dose: _____

☐ Observe pupil for _____ min. after medication taken

☐ Repeat peak flow measurement in _____ min.

☐ If peak flow between _____ OR symptoms do not improve:

☐ Repeat quick-relief medication; dose: _____

☐ Administer emergency medication: _____

Dose: _____ Route:_____

☐ Call 911 Emergency Services
☐ Emergency Action Plan attached
☐ Take the following actions: _____

6. **Physical activity or environmental modifications required:** _____

7. **Other pertinent information or recommendations;**

Authorized Healthcare Provider Authorization for Management of Asthma In School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name** ________________________**Signature** ______________________________
Date________ **Phone** ______________ **Address** _______________________**City** ___________________**Zip** _______
***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** ______________________________
Supervising Physician Name ______________________ **Address** _________________________ **Phone** ___________

☐ I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

Parent Consent for Authorization and Management of Asthma in School Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical healthcare service, asthma management, be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Healthcare Plan (IHP).

Parent(s)/Guardian(s) Signature (1)___________________________ (2) ___________________________ Date __________

Reviewed by school nurse (signature) Date

☐ **School nurse has informed principal about healthcare services provided for this pupil.**