Schuylkill Technology Center

Asthma Inhaler Request Form

Physician Signature Required

In accordance with PA House Bill No. 1113 and the Schuylkill Intermediate Unit 29 Medication Policy, students may self-administer asthma medication at school. The completed form should be in the health office and needs to be renewed yearly. Each student should carry his/her own inhaler in its original pharmacy labeled container. It should be clearly labeled with:

1. Student's name
2. Drug name and exact dosage
3. Time medication is to be taken

***To be completed by physician*:**

Student's Name: ____

Diagnosis: ____

Any activity restrictions (please explain): ____

____

Prescription medication: ____

Dosage and frequency: ____

I certify that the student listed above has been instructed in the use of self-administration of his/her asthma medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

____
Physician's Signature

____
Physician's Telephone No.

____
Date

I certify that the student listed above has successfully demonstrated the use of self-administration of his/her asthma medication. He/she understands the necessity to report each usage of the medication to the school nurse within ½ hour of use.

____
School Nurse's Signature

____
Date

Schuylkill Technology Center
Asthma Action Plan

Parent to complete

It is important for the health and safety of your child that this form be completed and returned to school if your child has the diagnosis of ***asthma***.

Student's Name: ______________________________Shop: ______________________
D.O.B.______________________

Contact Information (please include a phone number where someone can be reached at all times)

Parent/Guardian: ______________________________Relationship: _________________

Phone (Home) _______________________ (Work) ___________________

(Cell) ____

Alternate Contact: ______________________________Relationship: _________________

Phone (Home) ___________________________(Work) ____________________________

(Cell) ____

Student's Asthma Profile

Elements that trigger your child's asthma: *(Please circle all that apply)*

cats	dogs	molds	perfumes	dust/dust mites
cold air	humidity	smoke	chalk dust	physical exercise
bee venom	anxiety	viral infection	pollen	
special foods				

____

other triggers

____

Name___________________________________ *Side two*

Your child's usual asthma symptoms include:

____

____

Treat my child's asthma flare this way:

____

If an asthma flare is unresponsive to treatment within __________ minutes and/or my child's symptoms get worse, the school health professional should:

____

Daily asthma medication schedule:

Medication	Dosage	Time Administered
________________________	____________________	__________________
________________________	____________________	__________________

Parental Permission and Responsibilities

I, parent/legal guardian of the fore mentioned student, understand and agree to the conditions of this Plan and school policy regarding medical treatment of my child.

I request that my son/daughter be allowed to carry his/her asthma medication and self-administer as needed.

I permit school health professionals to seek emergency medical treatment for my child when deemed necessary and appropriate.

I hereby release the Schuylkill Technology Center, its employees, agents, and administration from any and all liability as a result of injury arising from self-administration of medication by my son/daughter.

___________________________________ ______________________________

Parent/Guardian's Signature ***Date***