CARROLL COUNTY SCHOOL DISTRICT

Primary Care Provider Authorization: Asthma (Side One)

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Triggers (Check all that apply to this child)

☐ Exercise ☐ Animals ☐ Fumes ☐ Carpet

☐ Strong Odors ☐ Pollen ☐ Molds ☐ Respiratory Infection

☐ Chalk Dust ☐ Change in Temperature ☐ Trees/Grass/Shrubbery

☐ Foods (Specify): _____

☐ Other (Specify): _____

Signs and Symptoms student will likely exhibit (Check all that apply)
***Note: Parent/Guardian will be contacted if symptoms persist**

☐ Coughing ☐ Wheezing ☐ Labored/Difficulty Breathing

☐ Other (Specify): _____

Recommended Preventative/Interventive Measures (Check all that apply)

☐ Encourage student to assume position of comfort ☐ Offer warm liquid to drink

☐ Nebulizer **(see back of form)** ☐ Encourage slow, even breaths

☐ Inhaler name and dosage: _____

☐ Other (Specify): _____

Emergency Plan of Action

* If color becomes pale, cyanotic (bluish), or ashen: Call EMS (9-911)
* If breathing stops: CPR certified staff should initiate rescue breathing (and CPR if necessary)
* Contact parent/guardian or emergency contact immediately
* Other (Specify): _____

Inhalers

This student has been trained to use his/her inhaler and should be allowed to carry and use their prescribed inhaler on his/her own. ☐ Yes* ☐ No

***It yes, please note: Student will be expected to carry and use his/her inhaler responsibly.**

Comments: _____

Please complete both sides if this form

Source: Jefferson County School Health Services

Primary Care Provider Authorization: Asthma (Side Two)

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Nebulizer Inhalation Therapy

Medication via the nebulizer will be given at school as follows:
☐ On a daily basis ☐ As needed

Medication No. 1 (Name and Dosage): _____
Medication No. 2 (Name and Dosage): _____
Time of day to administer: _____
Reaction or Side effects: _____
Comments: _____

_____ _____
Printed Name of MD, ARNP, or PA Address

_____ _____ _____
Signature of MD, ARNP, or PA Telephone No. Date

***Note to parent/guardian: Signing this form shall release _____ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____
Signature of Parent/Guardian Telephone No. Date

_____ _____ _____
Emergency Contact Telephone No. Relationship

Please complete both sides of this form

Source: Jefferson County School Health Services