**Natomas Unified School District**

**Asthma Management for the School Setting**

Last Name: First Name:

School Year: Effective Dates:

Date of Birth (mm/dd/yyyy): Medical Record #:

School Name: School Contact Phone #:

Parent/Guardian Name: Parent/Guardian Phone #:

Emergency Contact: Emergency Phone #:

Health Care Provider Name: Health Care Provider Phone #:

**Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack.**

***The following information is to be given by the health care provider*:**

Asthma Severity: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Asthma symptoms are triggered by: ❑ Exercise ❑ Dust ❑ Animal Dander ❑ Strong odors or fumes ❑ Mold ❑ Other:

Current Health status:

**Asthma Management at school:**

Medication Name: Dose/Puffs:

When to administer:

Instructions for administration:

Possible Side Effects:

Medication Name: Dose/Puffs:

When to administer:

Instructions for administration:

Possible Side Effects:

**Is student competent in self administering medication? ❑ Yes ❑ No**

**Is student competent to carry medication at school? ❑ Yes ❑ No**

Other orders/instructions from physician:

Restrictions/Limitations for Activity (list if any):

**Health Care Provider:** My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

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Name Signature Date

**Parent/Guardian (Authorization and Disclaimer):** I request that the school assist my child with the above asthma medications and the asthma action plan in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer asthma medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of asthma medications.

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Name Signature Date