

REGION 16 SCHOOL DISTRICT
BEACON FALLS AND PROSPECT
Prospect Elementary. Laurel Ledge Elementary
Long River Middle School. Woodland Regional High School

Dear Parent/Guardian,

Enclosed is Region 16's asthma paperwork. I am sending this to you as it was noted on your child's health form that he/she has asthma or asthma symptoms.

Please complete the forms and have your child's doctor fill out any necessary medication forms before school begins.

Medications must be brought to school by an adult, not the child. I will be at school three days before the start of the school year to accept papers and medications. **In the high school only, students may bring asthma medication to school only after being approved by their doctor and parent and after demonstrating competency to the school nurse.**

If you want to note anything, please use the spaces below. All information is kept confidential.

Thank you, The Region 16 Nursing Staff

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If your child **doesn't** experience any asthma issues anymore, you and your child's doctor must sign below.

Student Name

Parent Signature

Date

Physician Signature

Date

Asthma Action Plan

Student Information

Name of Student: _____ D.O.B.: _____

Grade: _____ Teacher: _____

Physical Education Days/Times: _____

Emergency Information

Parent/guardian: _____

Mother: Home _____ Father: Home _____

Work _____ Work _____

Cell _____ Cell _____

Physician: _____ Phone: _____

In case of emergency, contact:

1. _____

2. _____

3. _____

Asthma Emergency Action

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking or talking...
- Blue or gray discoloration of the lips or fingernails...
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken are:

- Activate 911 emergency system...
- Call parent/guardian or physician.

Triggers: _____

Personal best peak flow: _____

All current medications:

Medication	Dosage	Time

Medications to be given in school (if any):

Medication	Dosage	Time

Steps for an acute asthma episode:

1. _____
2. _____
3. _____
4. _____

Parent/guardian signature _____

Questionnaire for Parents of Child with Asthma

Student's Name _____ School Year _____

Teacher _____ Grade _____

Parent's Name(s) _____ Phone (h) _____ (w) _____

Name of Child's Doctor (for asthma) _____ Phone _____

The following information is helpful to your child's School Nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the School Nurse, please call for an appointment.

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma. (circle)

(Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days would you estimate he/she missed school last year due to asthma? _____

4. What triggers your child's asthma attacks? (Please check any that apply)

_____ Illness	_____ Emotions	_____ Medications	_____ Foods
_____ Weather	_____ Exercise	_____ Cigarette or other smoke	_____ Chemical Odor
			_____ Fatigue

Allergies (please list) _____

Other (please list) _____

5. What does your child do at home to relieve wheezing during an asthma attack? (Please check all that apply)

_____ Breathing Exercises	Takes medication:	_____ Inhaler
_____ Rest/relaxation		_____ Nebulizer
_____ Drinks liquids		_____ Oral medication

6. Please list the medications your child takes for asthma (everyday and as needed).

Name of medication	Dose	Frequency
(In school) _____		

(At home) _____		

Turn Over Please

If medications are to be given during school, a medication permission slip needs to be filled out yearly. Medications must be in the original labeled container. (When you get prescriptions filled you can ask the pharmacist to put them in two containers so you'll have one for school and one for home use.

7. If your child does not respond to medication, what action do you advise school personnel to take? _____

8. What, if any, side effects does your child have from his/her medications? _____

9. Has your child been taught how to use an extension tube, pulmonary aid, inspirease kit, or other device with his/her inhaler? Yes No

10. How many times has your child been hospitalized overnight or longer for asthma in the past year? _____

11. How many times has your child been treated in the emergency room for asthma in the past year? _____

12. How often does your child see his/her doctor for routine asthma evaluations? _____

13. Does your child need any special considerations related to his/her asthma while at school? (Check any that apply and describe briefly)

Modified gym class _____

Modified recess outdoors _____

No animal pets in classroom _____

Avoiding certain foods _____

Emotional or behavioral concerns _____

Special consideration while on field trips _____

Special transportation to and from school _____

Observation for side effects from medication _____

Other _____

14. Do you know what your child's peak flow rate is? Yes No Rate _____

15. Do you think your child holds back from participating in all school activities due to asthma? If so, please describe _____.

16. Have you ever attended an asthma education class? Yes No

Has your child had asthma education? Yes No