Moberly School District
Health Services FY2011 School Year

Authorization for Asthma Care at School

____
(date)

Dear ____________________________:

According to school health information, your child ___________________________ has been identified as having a history of asthma. In attempting to better meet your child's needs at school, I ask that you complete the enclosed form. This form enables school health personnel to administer needed medication to your child at school, as determined by your child's health care provider. It also enables the appropriate treatment of your child's asthma during an emergency situation.

If no medications are needed at school, you may **skip to** the middle of the next page and complete only the lower half of the page, beginning with the section for allergies. Please be certain to answer the three questions indicated with an asterisk (*), as this will help us to determine the severity of your child's asthma.

Please sign and return the form to school with your child. If medications are needed at school and/or if you have answered yes to any of the questions preceded by an asterisk, please call me at _______________________ to discuss your child's asthma care further. I look forward to working with you and your child.

Sincerely,

____
school nurse

Moberly School District
Health Services FY2011 School Year

AUTHORIZATION FOR ASTHMA CARE AT SCHOOL

Student Name:______________________________Grade______ DOB:_____________

*Medications that have been prescribed for use at school may be administered by a school nurse or authorized staff member if: 1) the medication has been appropriately labeled by a pharmacist under the direction of a licensed health care provider 2) the parent or legal guardian has granted permission below for the specific medication to be administered at school (Please note that medications that have been duly prescribed for **self-administration** by a school-age minor child require completion of an "Asthma Medication Self-Administration Form" as set forth by the Missouri Safe Schools Act of 1996).*

Medication Name_____________________ Dose____________ Time/Interval____________
Route/inhalation device _________________ Instructions ______________________________
____

Medication Name_____________________ Dose____________ Time/Interval____________
Route/inhalation device _________________ Instructions ______________________________
____

Allergies: list known allergies to medications, food, or air-borne substances _____________

*Has the child been hospitalized for asthma-related problems in the last three years? ______ If so, when? ________

*Has this child required urgent or emergency care due to asthma in the last three years? _____ If so, when? _______

*Has the child been instructed to take a medication daily to control asthma? _______ If so, when? ______________

***If the answer to any of these questions is yes, please call your child's school to schedule a time to meet with the school nurse. A history and needs assessment form should be completed. An asthma action plan should also be on record.**

I understand that the school nurse will inform other school personnel when needed and that only those school personnel with a need to know will be informed.I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and to inform the school nurse immediately in writing when a change in the above order is made.I understand that this permission is for the current school year only. I understand that the School Nurse must review this request prior to administering the first dose of this medication at school. I understand that the school nurse will notify me through phone contact and in writing if this request is denied or revoked. I understand that the first dose of any new medication cannot be administered at school. I understand that medication(s) remaining after the prescription end date or after the last day of school must be destroyed (equipment will be stored in the nurse's office).

I, the parent or legal guardian of the student listed above, give permission for administration of the above listed medications. I also grant permission for exchange of information with the health care provider to facilitate my child's asthma and allergy care.

Parent/Guardian:

Name:____ Home/Work Phone: ____________________

Emergency Contacts:
Name:____ Phone:________________________________

Health Care Provider: Name: ____ Phone**:**________________

►Signature of parent/legal guardian______________________________ **Date**__________