MOSINEE SCHOOL DISTRICT
ASTHMA/REACTIVE AIRWAY DISEASE (RAD) TREATMENT FORM

You have identified asthma or an allergy-related health concern for your child. In order to better care for your child during school hours please review and complete the following. **This form must be completed and signed by both the parent and doctor each school year.**

Student:______________________________ Grade:______ Date:______________

If you feel your child's asthma or RAD condition is no longer a medical concern for the schools, please check the following box, sign below, and return this form to school for our records.

❒ My child's asthma condition/RAD is not currently active. He/she has not had an episode in over one year.

Signature:______________________________ Date:______________

1. **Asthma (RAD) triggers:** (Check all that apply)

❒ Exercise ❒ Respiratory infections ❒ Animal dander
❒ Temperature changes ❒ Food ❒ Dust mites
❒ Tree, grass pollens ❒ Mold ❒ Strong odors or fumes

2. **Frequency of asthmatic episodes:**

❒ Seasonally, which season(s) ? ______________________________
❒ Daily ❒ Weekly ❒ Monthly ❒ Rarely
❒ Other, please describe: ______________________________

3. **List all your child's current medications, including inhaler(s):** (Star (*) which inhaler(s) will be given at school)

Name of medication	Dosage	Times given

4. **Yellow Zone (Sick Plan) symptoms:** (Check all that apply)

❒ Persistent cough ❒ Shortness of breath ❒ Wheezing ❒ Difficulty breathing
❒ Awake at night ❒ Chest tightness ❒ Peak flow less than _____ ❒ Other: ______________

5. **Please list the steps you follow for an acute asthmatic episode:**

1.______________________________
2.______________________________
3.______________________________

6. **The Mosinee School District recommends that capable students with asthma be permitted to carry and self-administer inhaled medications for the treatment and prevention of asthma symptoms. If the parent/guardian and practitioner wish to have the student so do, please check the box on the back of this form. (Inhaler for breathing conditions: May self-administer?) The student will then be responsible for bringing his/her inhaler on all field trips and excursions off campus.**

MOSINEE SCHOOL DISTRICT
PARENT / PRACTITIONER MEDICATION AUTHORIZATION

(Practitioner includes physician, dentist, podiatrist, optometrist, physician assistant and advanced practice nurse practitioner per 2001 Wisconsin Act 83.)

ALL medications given at school must have written permission by the parent/guardian. ALL **prescription** medication given at school, including students who carry and self-administer inhaler and Epi Pens, must have written instructions signed by the practitioner AND the parent/guardian. No practitioner signature is required for over-the-counter (non-prescription) medication *providing* the dose is within the manufacturer's guidelines and does NOT contain aspirin.

Student Name: ______________________________ Birthdate: ______________ Grade: ______

Medical Diagnosis(es) ______________________________

Medication(s)	Dosage & Route	Times Given at School	Specific Instructions

Medication order effective from: ______________________ until: ______________________

SELF-CARRY MEDICATION SECTION

Student can correctly use his/her medication? ❑ Yes ❑ No
Inhaler for breathing conditions: May carry self-administer? ❑ Yes ❑ No
Epi Pen for severe allergic reaction: May carry self-administer? ❑ Yes ❑ No
Insulin for diabetes: May carry self-administer: ❑ Yes ❑ No
Other medication: ______________________________ May carry self-administer? ❑ Yes ❑ No

PRACTITIONER SIGNATURE SECTION

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

Practitioner Signature: ______________________

Date: ______________________

Practitioner Name, Address, Phone: ______________________

PARENT/GUARDIAN SIGNATURE SECTION

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my son/daughter according to the instructions stated above and authorize them to contact the practitioner, if necessary.

Parent/Guardian Signature: ______________________ Date: ______________________

It is understood that:

1. All medications must be in an original container. Original pharmacy container must include the student's name, name of medication, dose, and time of administration on the label. Over-the-counter (OTC) medication must be in the original bottle/box/container and must include dosing instructions (quantity and frequency of administration with age). Meds sent in baggies, Tupperware, etc. will NOT be given.
2. Whenever possible, medication will be administered at home, before and/or after school hours.
3. Whenever there is any change in instructions for the above medication/s, a new form MUST be completed. A new form must also be completed for each and every school year.
4. Students who self-carry medications are responsible for taking these medications on all field trips.
5. Students will be sent by rescue squad to the emergency room after using an Epi Pen or Glucagon.