

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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Animal dander |
| <input type="checkbox"/> Temperature changes | <input type="checkbox"/> Food | <input type="checkbox"/> Dust mites |
| <input type="checkbox"/> Tree, grass pollens | <input type="checkbox"/> Mold | <input type="checkbox"/> 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)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Awake at night | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Peak flow less than _____ | <input type="checkbox"/> 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: _____

Practitioner Name, Address, Phone: _____

Date: _____

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.