Hamilton Southeastern Schools
Fishers, Indiana

Dear Parent or Guardian,

You indicated on your child's health card that they have asthma. In order to better understand your child and the severity of their asthma, we would appreciate your filling out the enclosed questionnaire and returning it to school as soon as possible. Thank you for taking the time to do this. If you have any questions or concerns that we would be able to help you with, please don't hesitate to call.

Sincerely,

HSE School Nursing Staff

Hamilton Southeastern Schools
ASTHMA ACTION PLAN

Student Name: _____ Teacher: _____ Grade: _____

1. How long has your child had asthma? _____

2. Rate the severity of his/her asthma. (circle one)
   (not severe) 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 attack? (check all that apply)
   _____ illness _____ emotions _____ medications _____ foods
   _____ weather _____ exercise _____ chemical odors
   _____ fatigue _____ other: _____

5. What does your child do at home to relieve wheezing during an asthma attack?
   _____ breathing exercises _____ uses inhaler
   _____ rest/relaxation _____ uses nebulizer
   _____ drinks water _____ uses oral medication
   _____ other: _____

6. Please list your child's medication(s).
   daily medication(s): _____

   medication(s) for asthma symptoms: _____

7. Please list the medication(s) that you will provide for the nurse to keep in the clinic.
   medication(s): _____

   symptoms that would indicate the need for medication(s): _____

   _____

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

9. How many times has your child been hospitalized in the past year for asthma? _____

10. How often does your child see a doctor for routine evaluations? _____

11. Do you know what your child's baseline peak flow rate is? _____ yes _____ no
    personal best flow rate: _____ red zone: _____

12. If your child suffers a severe asthma attack at school, what plan of action would you prefer school personnel to take?

    _____

    _____

Thank you for your time and assistance in assessing your child's special needs in school. By signing this form, you authorize permission for this information to be shared with any school personnel who would be responsible for your child during the school day. Thanks!

Parent Signature: _____ Date: _____

Hamilton Southeastern Schools
STUDENT MEDICATION GUIDELINES

The health of your child can directly affect school performance. The School Nurse is one team member available to help your child achieve their best. By adhering to the following guidelines, medication can be safely administered at school. All medication must be sent to school in its' original container. This container should be placed in a sealed envelope that is labeled with the student's name, medication name and dosage, pill count, parent/guardian's name and phone number. Medications will not be dispensed unless this policy is followed completely. It is the student's responsibility to see that their medicine is taken at the appropriate time.

Short Term Prescription Medicine (to be given ten days or less) must be accompanied by the following:
1. A written note from the parent/guardian specifying dates, times and dosage to be given.
2. Medication must come in the original prescription container labeled with child's name and instructions.
3. If it is an oral medication, send the exact amount of medication that will be used at school.
4. A written order from the physician if sample medication is provided.

Long Term Prescription Medication (given more than ten days) must be accompanied by the following:
1. A physician's order on a prescription pad or their signature on the form below.
2. A written note from the parent/guardian specifying dates, times and dosage to be given or completion of the form below.
3. Medication must come in the original prescription container labeled with child's name and instructions.

Non-Prescription Medication (cold medicine, cough syrup, etc., to be supplied by parent and given ten days or less) must be accompanied by the following:
1. A written note from the parent/guardian specifying dates, times and dosage to be given.
2. Medication must come in the original container labeled with child's name.
3. Please provide single doses only or the exact amount of medication that will be used at school.

Note: Medication may be sent home with a student if the parent gives written permission. However, to avoid having to transport medication back home with a student, please send in either a daily single dose or the exact amount required for the treatment period.

Please keep top portion for your information

Return bottom portion to Nurse

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

Student Name _____ Teacher _____

Name of medication	Dosage	Time	Dates to be given	Reason for use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Parent/Guardian Signature _____ Date _____

Physician Signature _____ Date _____

(Only required for long term prescriptions or sample medication)