ASTHMA INHALER USAGE AGREEMENT

If your child is asthmatic and will potentially need the use of an inhaler at school, please complete the form below and return to the School Office.

Student name ______________________________ School Year ________________

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Parent/guardian initial to indicate agreement

_____ **My child will use the inhaler with supervision in the School Office where it is kept.**

Medicine will be used correctly, in the proper amount, and records will be kept. All medication brought to school must be in its original container, with a signed Doctor and parent note giving the child's name, dose and time for medication to be given.

_____ **My child will keep the inhaler in his/her possession and use as needed.**

It is a good idea to have a spare inhaler provided by the parent. It would be kept for them in the School Office should they forget theirs or run out. Doctor and parent permission must be given for self-medication (see below). It is important that each student properly secure their inhaler on their person or keep it stored in their locker.

I give permission for my child to use the inhaler prescribed by his/her Doctor in the manner indicated above. I understand that he/she must follow the expectations listed if it the inhaler is be kept in student possession. I will notify the school of changes in medication or my child's condition.

Parent/Guardian Signature______________________________ Date ________________

Student expectations for carrying inhalers

- Student agrees to never share the inhaler with another person.
- Student agrees to carry the inhaler on their person or keep it stored in a locker.
- Student agrees that after using inhaler, if there is not marked improvement, he/she will go to the School Office immediately.

Student Signature ______________________________ Date ________________

To the Physician: Indiana Code 20-33-8-13 **Student Self Administration of Medication**

I can attest to the following:

- The student has a medical condition for which medication has been prescribed.
- The student has been instructed in how to self-administer the medication.
- The nature of the disease or medical condition requires emergency administration of the medication.
- I support the "**Asthma Action Plan**" provided to the school by the parent.

Physician Signature ______________________________ Date ________________

ASTHMA ACTION PLAN

IMPORTANT INFO	EXERCISE-INDUCED FLARE-UP
Name: ______	Instructions for an exercise-induced flare-up
Date: ______	Medicine: ______
Doctor: ______	How much: ______
Phone: ______	When: ______
Emerg. Contact: ______	Additional instructions:
Phone: ______	

TRIGGERS (list)

THE SAFE ZONE

Use these daily controller medicines.

Symptoms:

~ Easy breathing

~ No coughing/wheezing

~ Can work and play

Medicine	How much?	How often or When?

THE CAUTION ZONE

Continue daily medication, and add:

Symptoms:

~ Some shortness of breath

~ Coughing/wheezing

~ Chest tightness

~ Difficulty doing normal activities

Medicine	How much?	How often or When?

THE DANGER ZONE

Take these medicines and call your doctor now.

Symptoms:

~ Severe breathing problems

~ Cannot do normal activities

~ Difficulty walking and talking

Medicine	How much?	How often or When?

IF SYMPTOMS DON'T IMPROVE IN 15 MINUTES, AND YOU CAN'T CONTACT THE DOCTOR, GO TO THE HOSPITAL OR CALL 911.