school for little children

Questionnaire for Parents/Guardians of a Child with Asthma

Childs Name:	DOB:

1. How long has your child had asthma?_____

2. Please rate the severity of his/her asthma (circle one): **Not severe** ☐☐☐☐☐ **Severe**

3. What triggers asthma in your child? (Things that cause wheezing) Check all that apply:

☐ Weather (cold, windy, rain)
☐ Illness
☐ Foods
☐ Exercise
☐ Tiredness/Emotional Factors
☐ Cigarette or other smoke
☐ Chemical odors
☐ Environmental Factors: Pollen, Mold, Dust, etc.
☐ Other: _____

4. What are the early signs and symptoms of an attack?_____

_____

5. Is medication prescribed for the condition? ☐ Yes ☐ No

6. What is the name of the medication? _____

_____

7. Will the medication need to be given at the center? ☐ Yes ☐ No
(If yes, please complete the Physician and Parent Consents to Administer Medication)

8. Has your child had any side effects from the asthma medication? ☐ Yes ☐ No

If yes, please describe:_____

9. Has hospitalization been needed in the past for asthma attacks? ☐ Yes ☐ No
If Yes, please explain (when, how often, etc.) _____

_____

10. Does your child know she/he has asthma? ☐ Yes ☐ No

11. Does your child usually tell an adult when she/he is having a reaction? ☐ Yes ☐ No

12. Will your child's activity need to be modified while at school? ☐ Yes ☐ No

    If yes, what is/are they?_____

13. What do you usually do when your child has a reaction? _____

The Usual Treatment For A Severe Asthma attack Is To:

- Administer prescribed medication per written doctor's orders
- Notify Parents/guardians:

  Students Home phone #:

  Mother/guardian name:_____phone:_____

  Father/guardian name:_____phone:_____

Name of Doctor:_____Doctor phone:_____

Where does your child receive his/her asthma care (name of clinic):_____

Parent Signature: _____ **Date:** _____

- *This information should be documented on the Child Enrollment Status form*
- *This information should be shared with the education & lunch and learn staff*

Emergency Health Care Parent Agreement
2017/2018

_____I AM submitting an Emergency Health Care Plan completed and signed by my child's doctor.

- I understand that I am responsible for monitoring my child during special school events where food is served.
- I understand that I am responsible for keeping my child's medication up to date and at school.
- I agree to attach an allergen-notification sticker to my child's lunch box stating his/her allergies.
- I understand that SLC shares space with other organizations and is unable to control what foods are brought into the school when school is not in session.

Signature of Parent/Guardian_____ Date_____

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_____I am NOT submitting an Emergency Health Care Plan.

According to the health information you have provided to us, your child has a history of _____. Since we do not have an Emergency Health Care Plan on file for your child, please sign this agreement to verify the following information:

- I am **NOT** submitting an Emergency Health Care Plan for my child.
- My child's doctor has informed me that his/her allergy or asthma is **not** serious or life threatening and does not require rescue medication.
- My child will not take rescue medication at SLC for the above stated condition per my decision.
- I understand that in case of a medical emergency, 911 will be called.
- I understand that I am responsible for monitoring my child during special school events where food is served.

Signature of Parent/Guardian_____ Date_____

Medication Consent Form

To be completed by a Parent/Guardian

I, _____, parent/guardian of _____ request that the staff of School for Little Children administer the prescription or non-prescription medications listed below to my child. I agree and fully understand that SLC will not be responsible for any side effects, adverse reactions or medical emergencies that my child may experience as a result of taking the medication. I also understand that the person who will be administering the medication is not trained by a health care professional.

Child's Name:_____ **DOB:**_____

Emergency contact: _____ **phone**:_____

Child's known allergies:_____

Reason Child is taking the medication:_____

Name of Medication	
Expiration Date	
Dosage to be given	
Route of Administration (shot, liquid, etc.)	
Time/Frequency to be administered	

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Physician Name:_____**Physician Phone:**_____

- I give the SLC staff permission to speak to the prescriber above and to exchange information related to my child.
- I authorize SLC staff to administer the medication as specified to_____

Parent Name_____

Parent Signature:_____Date_____

Asthma Action Plan

Child's Name _____ **Child's Date of Birth** _____

Doctor's Name and Number _____

Category of Severity–Check one:

☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

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CONTROLLED
No symptoms.
Breathing is good.
This is where your child should be every day.

Green Zone Action Steps

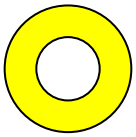
1. Avoid triggers that bring on your child's asthma (smoke, cold weather, allergens and infections).

2. Take _____ 10-15 minutes before exercise *if needed.*

3. Take your daily Green Zone maintenance medicines as follows:
_____
_____
_____

These medicines are used to control and prevent asthma symptoms. Do not stop them without talking to your child's doctor.

CAUTION
Coughing, wheezing, runny nose, watery eyes.
Take action to get your asthma under control.



Yellow Zone Action Steps

1. Tell an adult.

2. Give _____every _____ hours until your child returns to the Green Zone (no symptoms).

3. *Always* check your child's breathing after giving rescue medicine.

4. Keep taking your Green Zone maintenance medicines

Let your child's doctor know if your child drops into the Yellow Zone more than once a week or if they stay in the Yellow Zone 24-48 hours. Your child's Green Zone maintenance medicine may need to be changed. Examples of rescue medicines are albuterol (proventil or ventolin) and maxair.

EMERGENCY
Chest being sucked in (retractions). Nostrils flaring. Medicine not helping. Breathing hard and fast. Activity level down.
Your child's asthma symptoms are serious!

Red Zone Action Steps

1. Tell an adult.

2. Give _____ immediately and check your child's breathing.

3. If your child is not back in the Yellow/Green Zone, repeat above step every _____ for a maximum of _____
_____

4. Call your doctor at _____ to notify him or her of your Red Zone event.

OR

See your doctor right away if your child's lips or fingernails are blue or if they are struggling to breathe after taking their medicine.

Doctor's Signature: _____ **Date:** _____

Clinic Stamp: