LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Student Health Services

Documentation Required For Student

Identified As Having Asthma

Dear Parent or Guardian:

You have disclosed that _____ has asthma. The District requires additional information in order to take necessary precautions for the student's safety and to authorize treatment of the student in the event of an asthma flare at school or at a school-related activity. Attached to this letter are the following forms:

1. "Welcome Letter" with detailed information about asthma management at school
2. Asthma Action Plan for Home and School*;
3. Self-Carry/Administration of Medication Authorization*;
4. Request for Medication Administration;
5. Release/Consent to Request Medical Information.

Forms noted with an asterisk must be completed and signed by an MD, DO, NP, or APRN. Please return these forms to your school nurse as soon as possible. Any additional information or documentation that will help assist the campus in recognizing the signs and symptoms of an asthma emergency are greatly appreciated.

Sincerely,

LTISD Student Health Services

Welcome Letter for Student

Diagnosed with Asthma

Dear Parent or Guardian:

Our school team is looking forward to an excellent year for your child. As part of our school's asthma management program, your child will work with the school nurse and other staff to follow his or her asthma action plan and learn how to reduce asthma symptoms and asthma attacks.

In order to provide the best possible asthma management for your child at school, we ask for your help with the following. Please:

- Get a written asthma action plan from your child's asthma care provider and give a copy to the school nurse. This asthma action plan states your child's treatment goals, medications and peak flow plan, and steps to reduce your child's asthma triggers. Please be sure the asthma action plan includes instructions for managing symptoms during special activities at school or away from school. Activities and events can include recess, gym, outdoor play, field trips, parties, and art and music class. You may use the enclosed form or a form from your child's health care provider. if your child does not have a primary care provider, please talk with our school health team to work out a plan to support your child's asthma needs.
- Fill out the enclosed medication administration form(s) for any medication to be given at school or during school-sponsored activities away from school and submit it to the school health office. Provide the health care provider's signature and the enclosed form if your child is to carry and take his or her own medication at school and school-sponsored activities. Please bring in medications in original containers with pharmacy labels; do not send medication to school with your child unless the child has self-carry authorization. Keep medications refilled as needed, and check for expiration dates that may occur during the school year. If your child carries his or her own medication, and you would like to leave a second inhaler to store at school, you are welcome to do so.
- Meet with the school nurse—before school starts and as needed through the school year— to

discuss your child's condition, medications, devices, and asthma triggers.

- Collaborate with school nurse and teachers to develop a plan for communication and handling any work or tests your child might miss during school absences due to asthma. Also meet with physical education teachers and coaches to discuss any special needs related to exercised-induced asthma.
- Prepare your child. Be sure your child understands his or her medication plan and how to handle symptoms, triggers, and restrictions. Discuss school policies that relate to your child's asthma management (such as rules about medication use).
- Tell school staff about any changes in your child's condition or asthma action plan.
- Tell your child's doctor or other health care provider about school services and supports for helping your child manage his or her asthma.

Our asthma management program also includes the following components, which will help support your child's asthma control while at school:

- Asthma training for all school staff so they are prepared to follow students' asthma action plans, to identify asthma symptoms and warning signs of asthma attacks, and to handle emergencies related to asthma
- Improved indoor air quality filtration to promote a healthy environment and reduce asthma triggers
- A supportive environment that encourages respect for others

Thank you for working with us to help your child. If you have questions or concerns about keeping your child's asthma well controlled while at school, please contact your campus nurse.

American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone — Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone — Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone — If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping. **Get Help Now**

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Request for Medication Administration

Student: _____ DOB _____ Grade: _____ Campus: _____

Medication: _____ Dose: _____

Take medication: □ by mouth □ via inhaler □ topical (cream) □ injection □ other _____

Condition for which medication is given: _____

To be given: □ Entire School Year - or - □ The following dates: ___ /___ /____ to: ___ /___ /____

When: □ At the following time(s): _____ - or - □ As needed every _____ hours

Special considerations/side effects: _____

For Daily Medications: □ Yes, please administer daily medication on field trips
□ No, please do not send daily medication on field trips

Other medications taken at home: _____
List any food or drug allergies: _____

Must be signed by a physician for any of these reasons:

□ prescription given more than 10 school days (daily medication)
□ over-the-counter more than 5 consecutive days
□ over-the-counter to be given at higher than labeled dose

Parent/Guardian: I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.	
Signature:	Date:
Printed Name:	Phone:

Physician: I request that the student receive this medication during the school day as instructed above.	
Signature:	Date:
Printed Name:	Phone:

School: Medication was received by:		
Signature:	Date:	Quantity Received:
Printed Name:	Phone Ext.:	Expiration Date:

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Self-Carry/Administration of Medication Authorization

A responsible, trained student is permitted to carry and/or self-administer medication on his/her person for immediate use in a life-threatening situation with a written order from a physician/prescribing health care provider, parent/guardian request, and school nurse and principal approvals.

Student: _____ Grade: _____ Date of Birth: _____

Condition for which medication is administered: _____

Name of medication: _____ Dose: _____

Method of administration for medication: _____

Timing /Indication for administration of medication: _____

Side effects to be noted/reported: _____

Other recommendations:_____

Dates of administration: From _____ to _____ (not to exceed one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician: _____ Telephone(s): _____

Physician's Signature: _____ Date: _____

Parent/Guardian Authorization

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, the medication name, date of the original prescription, strength and dosage of the medication, and directions for use. No more than a 30 day supply of the medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or the end of the medical order.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Principal/School Nurse Approvals

We accept the parent request and physician statement above. We will permit/assist the student to be responsible with this self-carry medication, but reserve the right to withdraw the privilege if student shows signs of irresponsibility, or if there is a reported safety risk. In the event that a safety risk has been determined, the administration will contact parent/guardian as soon as possible.

School Nurse's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

Release/Consent to Request Medical Information

Student Name _____

Date of Birth _____ **Grade** _____ **Campus** _____

Please authorize the person named below to request specified records containing confidential information regarding the above-named student.

From: Lake Travis Independent School District

To: _____
Physician to whom the request is made

_____
Campus

_____
Phone number

_____
Address

_____
Address

_____
City/State/Zip

_____
City/State/Zip

_____
Fax

_____
Fax

Records to be released

□ Medical History
□ Physician's Orders
□ On-going Communication

Purpose of Disclosure

Develop an appropriate health care plan

To clarify student's medical needs

_____ at: _____
School Nurse Phone Number

□ Yes □ No I have been fully informed and understand the school's request for my consent, as described above. This information will be requested upon receipt of my written consent.

□ Yes □ No I understand that my consent is voluntary and may be revoked at any time.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name