

# Asthma Forms

Please complete the attached packet if your child has been diagnosed with asthma that requires medication. Forms **MUST** be signed by a Healthcare Provider.

H-3-2

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
MEDICATION DURING SCHOOL DAY**

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0495). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. RETURN COMPLETED FORM TO THE SCHOOL IN WHICH THE STUDENT IS ENROLLING.

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. section, 2164 (Department of Defense Domestic Dependent Elementary and Secondary Schools) and 20 U.S.C. sections 921-932 (Defense dependents' education system).

**PRINCIPAL PURPOSE:** Obtain health related information about a student enrolling or enrolled in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and promote a safe school environment. Determine services to be provided for a student in an equal opportunity to participate in public education.

**ROUTINE USES:** DoDEA may release information without prior consent within the Department of Defense (DoD) when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a (b) (1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a (b) (2-12), and the "Blanket Routine Uses," published at <http://dpcl.dod.mil/Privacy/SORNsIndex/BlanketRoutineUses.aspx>. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

**DISCLOSURE:** Voluntary. However, failure to provide the requested information may result in the delay or denial of student services.

**Medication During School Day**  
PCM/ Sponsor/Parent/Guardian Signatures

\_\_\_\_\_ School (*enter name of school*)

**To be completed by Physician/Primary Care Manager**

Name of Student \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Diagnosis and indication for medication administration \_\_\_\_\_

Medication	Dosage	Time	Route	Duration	Possible side effects

Precautions/Restrictions: \_\_\_\_\_

\_\_\_\_\_  
Physician/Primary Care Manager (PCM) Signature & Stamp

\_\_\_\_\_  
Clinic Phone number

**To be completed by Sponsor/Parent/Guardian. Please return completed form to the school nurse.**

I hereby give permission for my dependent (student's name) \_\_\_\_\_ to receive, from the school nurses and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. It is also my responsibility to pick up the medication at the end of the school year or when the medication is no longer to be administered to my dependent. I understand that medications left in the School Health Office after the current school year will be destroyed.

I give permission for the school nurse and my dependent's health care providers to exchange information about the diagnosis for which this medication is prescribed and my dependent's response to the medication. This permission is valid for this current school year, only. I understand that it is my responsibility to inform the school of changes in my dependent's health status or contact information as originally provided to the school.

**NOTE:**

- Prescription medications must be brought to school in the original container, labeled by the pharmacy, stating the name of the student, the medication, reason for administration, dosage, route, time of administration and the date issued.
- Prescribed medications purchased as an over-the-counter medication and not subject to a pharmacy label, must be brought to school in the original *unopened* container labeled by the sponsor/parent/guardian with the student's name, date of purchase and reason for administration.
- All medications will remain at school for the duration of the prescription.

\_\_\_\_\_  
Signature of Sponsor/Parent/Guardian

\_\_\_\_\_  
Date

**To be completed by Nurse**

Date Medication received: \_\_\_\_\_ Amount of medication received: \_\_\_\_\_ Expiration date of medication: \_\_\_\_\_

Nurse's Notes: \_\_\_\_\_

\_\_\_\_\_  
Signature of School Nurse:

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
REQUEST FOR ASTHMA INFORMATION**

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**Request for Asthma Information**

Date \_\_\_\_\_ **SCHOOL (enter school name)**

Please provide information regarding the asthma condition of your child/dependent so his/her welfare and safety can be best managed at school. If there is other information you would like to provide, please write on the reverse side of this form. Thank you for this valuable information. If you have any questions, or concerns, please contact the school nurse.

School Nurse \_\_\_\_\_

Phone No. \_\_\_\_\_

Email Address \_\_\_\_\_

**To be completed by Sponsor/Parent/Guardian. Please return completed form to the school nurse.**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

When was your dependent diagnosed having asthma? At age \_\_\_\_\_

How often does your dependent have an attack that requires an emergency visit to the doctor or hospital?

\_\_\_\_\_ weekly \_\_\_\_\_ monthly \_\_\_\_\_ yearly \_\_\_\_\_ never

What usually triggers your dependent's asthma? (Check all that apply.)

illness       exercise       emotions       foods  
 smoking/odors       weather       medications       allergens

Describe last asthma attack, what happened, how it was treated, how long it lasted: \_\_\_\_\_

What is the severity of your dependent's asthma (as determined by your health care provider)? Circle one:

\_\_\_\_\_ mild intermittent / mild persistent / moderate persistent / severe persistent

Has your dependent ever had allergy testing? \_\_\_\_\_ No \_\_\_\_\_ Yes

Allergies identified: (list) \_\_\_\_\_

Is there a smoker in the home? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you use a Peak Flow Meter at home? \_\_\_\_\_ No \_\_\_\_\_ Yes Personal Best Peak \_\_\_\_\_

List all asthma medications taken:

1. Long-term (daily) control medications: \_\_\_\_\_

2. Short-acting/quick relief medication: \_\_\_\_\_

3. Other medications taken: \_\_\_\_\_

Have you or your dependent ever attended an asthma education class? \_\_\_\_\_ No \_\_\_\_\_ Yes When & where? \_\_\_\_\_

Does your dependent have an asthma management plan/asthma action plan? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, please attach a copy.