Galloway Township Public Schools Child Care Program
101 South Reeds Road
Galloway, MJ 08205
(609) 748-1250
http://www.gtps.k12.nj.us

ASTHMA QUESTIONNAIRE

You have informed the school nurse that your child has asthma. In cooperation with your child's physician, please complete the information below and return it to the school nurse. **This form is only valid for the current school year.**

Student's Name: ______________________________ Grade: ______ Date of Birth: __________________

MEDICAL History: (To be completed by parent/guardian and physician)
Briefly describe what causes the child's asthma: ____
____

What are his/her signs of onset of an asthmatic episode? ____
____

Does exercise induce episodes of asthma? _______ If so list the types of exercise: __________________
____

Do certain weather conditions affect your child's asthma? _________ If so, list them: ________________
____

Please list any medications that are taken routinely: ____
____

Does this child suffer any side effects from the medication? _______ If so, list them: ________________
____

EMERGENCY PHONE NUMBERS:
Mother: Home ____________________________ Work ___________________________
Father: Home ____________________________ Work ___________________________
Other: Name ____________________________ Relationship _____________________
Home ____________________________ Work ___________________________
Preferred hospital: ______________________________

I understand that this information may be shared with appropriate staff members having contact with my child.

____ _________________________________
Parent's/Guardian's Signature Date

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PLBL05ars

Student's Name: _____________________________ Grade: ______ Date of Birth: _________________

PHYSICIAN PERMISSION TO ADMINISTER MEDICATON
TO BE COMPLETED BY PHYSICIAN

EMERGENCY PROCEDURES:

Steps for an acute asthma episode:

1. ____
2. ____
3. ____

MEDICATION ORDER:

Name of medication ____

Dosage _______________________ Route ______________________Time __________________________

Frequency _______________________________Indications for use_________________________________

Side effects ____

Duration of order ____

List other medications child is on which may enhance, alter or impact this medication ___________________

____

May be given before gym/exercise	yes	no
May repeat medication after _____ minutes if no response to initial treatment	yes	no
Physical activities restricted	yes	no
May self-administer for asthma or another potentially life-threatening illness under adult supervision	yes	no
Is capable of and has been instructed in the proper method of self-administration of medication	yes	no

____ ____

Physician/Health Care Provider's Signature/Stamp Date

____

Please Print Physician/Health Care Provider's Name, Address, and Phone Number

PARENT PERMISSION TO ADMINISTER MEDICATION

I request and grant permission for the school nurse to administer medication to my child, _____________________ as prescribed by his/her physician as indicated on the reverse side this form and as per the policy of the Galloway Township Board of Education and State law. I understand that medication is to be brought to school by myself in the original prescription bottle/box labeled properly by the physician or pharmacist.

___________________________________ _______________________________ ___________________________________

Parent's/Guardian's Signature Date Phone Number

PUPIL SELF ADMINISTRATION OF MEDICATION PERMISSION

The Board of Education shall permit self administration of medication for **asthma or other potentially life threatening illnesses** by pupils in grades 1 through 8, both on school premises during regular school hours and off site or after regular school hours when a pupil is participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. Life threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequel that may indicate the potential loss of life (i.e. adrenaline injection in response to anaphylaxis) See Policy 5141.21

My child, ______________________ has my permission to administer his/her own medication _______________________ for **asthma or other potentially life-threatening illnesses** both on school premises during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. I acknowledge that the Assumption Regional School shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and it's employees or agents against any claims arising out of self-administration of medication by my child.

___________________________________ ____

Parent's/Guardian's Signature Date