PARENT TO COMPLETE

Asthma Questionnaire for Parents

Child's Name_____ Grade_____

Parent's Name_____

1. At what age was your child's asthma diagnosed? ____ /____ /____
   Month Day Year
2. What are your child's usual signs / symptoms during an asthma attack?
   [ ] wheezing [ ] cough [ ] difficulty breathing
   [ ] chest tightness [ ] anxiety [ ] other_____
3. How many days of school would you estimate your child missed last year due to asthma? _____
4. In the past year, how many times has your child been treated in the emergency room for asthma symptoms? ____
5. In the past year, how many times has your child been hospitalized (overnight or longer) for asthma symptoms? ____
6. What triggers your child's asthma symptoms?
   [ ] exercise [ ] stress [ ] cold air [ ] illness
   [ ] allergies to_____
   [ ] smoke (Does anyone smoke at home?_____
   [ ] other_____
7. What does your child do at home to relieve the symptoms during an attack?
   [ ] rests [ ] drinks fluids [ ] uses breathing exercises
   [ ] checks peak flow [ ] takes medications
   [ ] other_____
8. Does your child know when he/she needs medication? [ ] yes [ ] no
9. If your child uses an inhaler, does he/she use a spacer? [ ] yes [ ] no

Comments:

Parent Signature_____Date_____

****EMAIL (REQUIRED):_____****

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

PARENT COMPLETES

CHICAGO PUBLIC SCHOOLS | CPS

PARENT REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student	Birth Date	ID Number
Address	Telephone	Zip Code

_____ has requested that my child self-administer medication
Name of Physician

Self-administration of medication during school hours. I (Mother, Father, and Legal Guardian) give permission for _____ to take medication during school hours. My physician will also submit a written statement that my child is capable of self-administering the medication at school.

By signing this statement, I am also acknowledging that Chicago Board of Education its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the pupil. I agree to also indemnify and hold harmless the Board and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication or use of an epinephrine auto-injector by the pupil.

_____
Signature of Parent / Guardian

_____
Address

_____
City Zip

_____
Home Phone Cell Phone Business Phone

_____
Date

EMAIL_____

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

COMPLETE A RELEASE FOR EVERY 2 PROVIDERS

Chicago Public Schools

Consent for Release/Exchange of Student Records and Information

Student's Name: _____ Date of Birth: ____/_____/_____

I hereby give permission to release/exchange/disclose the following:

☒ **All School Student Records**, including, but not limited to: personally identifying information; cumulative-permanent record; special education records; academic transcript; discipline records; health records; attendance records; and test scores.

Only Specific School Records:

- ☐ Personally Identifying Information
- ☐ Special Education Record (e.g. IEP, Evaluations, 504 Plans)
- ☐ Cumulative/Permanent Record
- ☐ Health Records
- ☐ Disciplinary Records
- ☐ Progress Monitoring Data
- ☐ Attendance Records
- ☐ Test Scores
- ☐ Other (Specify): _____

Health/Medical Information:

- ☐ Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records
- ☐ Records regarding treatment for the following condition or injury _____
- ☐ Records covering the period of time between _____ and _____
- ☒ Other: ALL MEDICAL/BEHAVIORAL HEALTH RECORDS THAT MAY IMPACT ON STUDENTS EDUCATIONAL PERFORMANCE.

This information is to be released/exchanged between:

Agency/Doctor: 1)_____ 2)_____

Phone: 1)_____ 2)_____

FAX 1)_____ 2)_____

AND

Chicago Public Schools, District #299

School/Department:_____

Attn:_____

Purpose: This information is to be disclosed upon request and will be used for the following purpose(s):

- ☒ Educational evaluation and program planning
- ☒ Medical evaluation and treatment
- ☒ Health assessment and planning
- ☐ Referral to a separate day school/residential facility+
- ☒ Independent Educational Evaluation
- ☐ Other: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act* (740 ILCS 110/1 et seq.). I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to the local school district representative. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district may not be protected by HIPAA Privacy Rules, but will become educational records protected by the *Family Educational Rights and Privacy Act* (20 U.S.C. Section 1232g). I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I understand that I have the right to inspect and copy educational records and to challenge their contents. +I acknowledge that limiting the release/exchange or disclosure of records to one separate day school/residential facility may impact the District's ability to timely place the Student in a non-public facility.

This authorization is valid for one (1) calendar year from the date of signed consent indicated below.

_____ _____

Parent Signature Date

_____

Witness Signature Date

_____

Student Signature* Date

*Student signature required for mental health records if Student is 12 years of age or older

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

PHYSICIAN COMPLETES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN'S REPORT ON CHILD WITH ASTHMA

_____
(Last Name) (First) (Middle) (BD) (ID Number))

_____
Home Address Zip Code Other Town

_____
Father's Name Mother's Name Telephone

_____
School Grade Non-Attending

Dear Doctor,

The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files. __

School Nurse

Asthma Severity

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

Triggers

☐ Pollen ☐ Mold ☐ Dust ☐ Animal Dander ☐ Food (s) _____

☐ Exercise ☐ Stress ☐ Carpet ☐ Chalk Dust ☐ Other _____

☐ Respiratory Infections ☐ Change in temperature

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		
4.		

Does the Student use any of the following aids?

☐ Holding chamber ☐ Holding Chamber w/mask ☐ Mask ☐ Other _____

Peak Flow Meter

Personal Best _____ Monitoring Time (s) _____

Green Zone _____Yellow Zone (Take Rescue Meds) _____ Red Zone (Medical Alert) _____

Special Needs: *(check all that apply)*

☐ P. E. / Exercise Modification ☐ Transportation ☐ Rest Periods

☐ Special Diet ☐ Recess / Field Trips ☐ Animals in class ☐ Other

Please Explain _____

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____**Telephone #** _____ **Fax #**_____

Physician's Signature _____**Date** _____

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN'S REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has **ASTHMA**
Name of Disease, condition, or Syndrome

I am requesting that the above named student be allowed to self-administer the following medication **under adult supervision** during school hours:

Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler
ALBUTEROL	**INHALER / NEBULIZER**
Dosage	Time to be given

Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____ **Hospital Affiliation**_____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____ **Date** _____

*This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has ASTHMA
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

ALBUTEROL	INHALER / NEBULIZER
Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler
Dosage	Time to be given

Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____**Hospital Affiliation** _____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____**Date** _____

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

Name _____ DOB ____/____/_____

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

Asthma Triggers (list) _____

Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it
	_____	_____	_____
	_____	_____	_____

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity

☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add _____ ☐ Change to _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Emergency Contact Name _____ Phone (_____) _____-_____

Healthcare Provider Name _____ Phone (_____) _____-_____

1-800-LUNGUSA | LUNG.org

Date ____/____/_____