



**Galloway Township Public Schools**

101 South Reeds Road  
Galloway, NJ 08205  
(609) 748-1250  
<http://www.gtps.k12.nj.us>

**ASTHMA QUESTIONNAIRE/ACTION PLAN**

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

**OVER>>>>>**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### PHYSICIAN PERMISSION TO ADMINISTER MEDICATION 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  
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### 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 its employees or agents against any claims arising out of self-administration of medication by my child.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_