Galloway Township Public Schools
101 South Reeds Road | Galloway, NJ 08205
Phone: (609) 748-1250 | Web: www.gtps.k12.nj.us

ASTHMA QUESTIONNAIRE/ACTION PLAN

Dear Parent/Guardian:

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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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

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 this form and as per the policy of the Galloway Township Board of Education and State law.

._____ _____ _____

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 Galloway Township Public School District 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

Revised 6/7/2023