(SCHOOL DISTRICT LETTERHEAD)

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma may be affecting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ school performance.

**The following information is provided for your information and records:**

* Has missed \_\_\_\_\_\_\_\_\_\_\_\_\_ days in \_\_\_\_\_\_\_\_\_\_\_\_\_ [period of time], possibly due to asthma.
* Needs an updated Asthma/Allergy Action Plan fitting student’s current asthma status.
* Does not have prescribed quick-relief medication at school (has not provided to school health office and does not self-carry).
* Does not participate in PE because of symptoms related to asthma.
* Visits the school health office frequently with symptoms related to asthma.
* Has needed emergency management of asthma (Emergency Response Protocol/911).
* Has the following suspected medication side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We have observed the following components of asthma control grid below (circled):**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Symptoms:*** | **≤2x per week** | **>2x per week** | **Throughout the day** |
| ***Peak Flow, % normal (personal best):*** | **>80%** | **60–80%** | **<60%** |
| ***Interference with normal activity:*** | **None** | **Some limitation** | **Extremely limited** |

Parents/ guardians have provided written permission for us to exchange the student’s health information with you (second page).

**In order to help your patient control his/her asthma while at school, please help us with the following:**

* Complete an Asthma/Allergy Action Plan (enclosed) and fax to school.
* This student has no prescribed quick-relief medication at school.
* This student’s quick-relief medication is past its expiration date.
* Please discuss with the parent/guardian the benefit of sending a second inhaler to school if student carries own medication, so that one is always available when needed.
* The student has difficulty using his/her metered-dose inhaler and is using it improperly. Prescribing a valved-holding chamber/spacer may help this student use the inhaler more effectively.
* The student’s asthma is not well controlled at school. Please reassess this student for asthma, his/her current medication use (see asthma control grid noted above) and teach correct inhaler technique.
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please contact me if you have any questions or concerns.***

Sincerely,

School Nurse (signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal (signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best days/times to call: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I permit my child’s doctor (named above) to exchange information with school staff regarding my child’s asthma and to provide specific medical information.

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_