ADDRESSING ASTHMA IN SCHOOL AND EARLY CHILDHOOD SETTINGS

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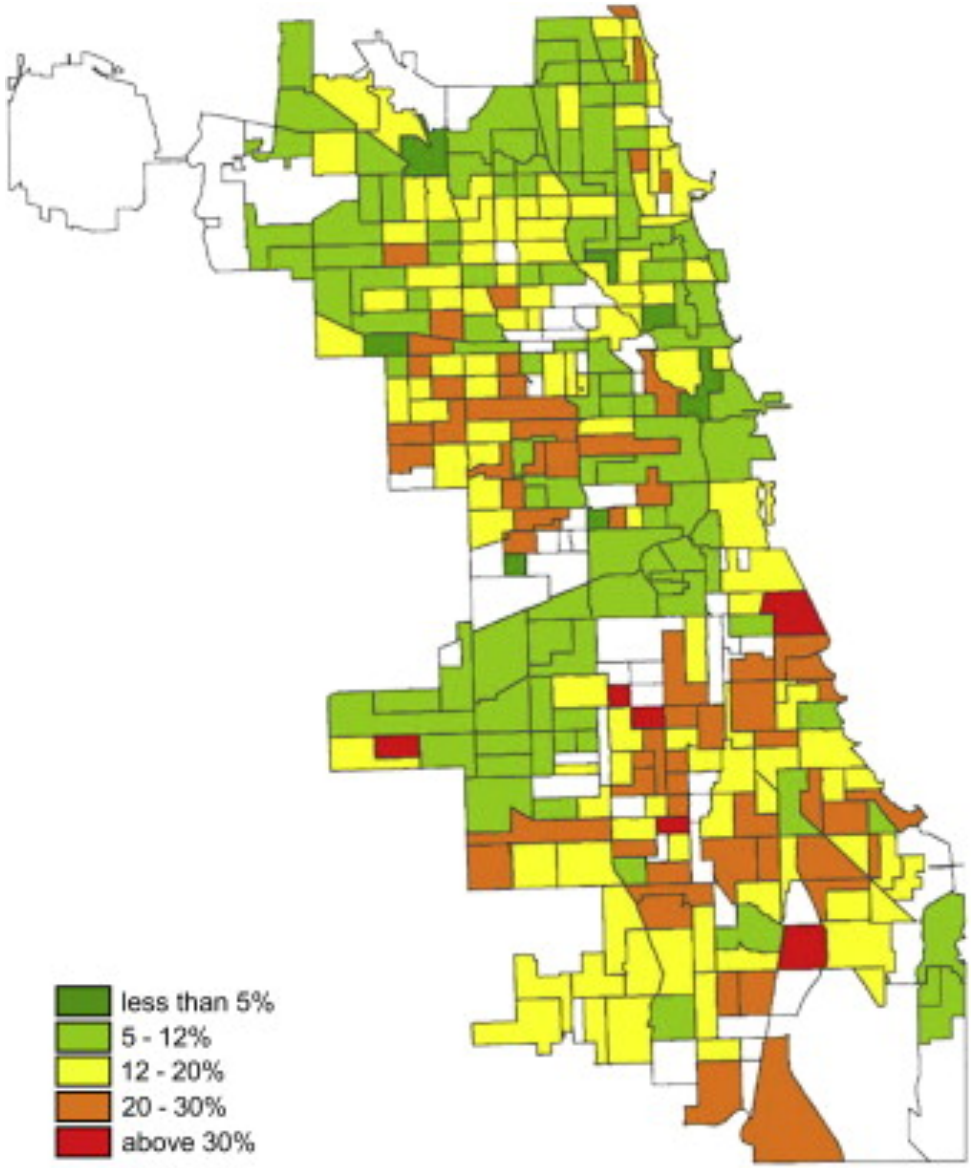
ASTHMA EPIDEMIC IN CHICAGO



*Neighborhoods with greater than 15 children from our sample were included in the analysis

12.9 % of Chicago children have asthma

Asthma accounts for more than 14 million absences from school each year.

Asthma is the third-ranking cause of hospitalizations for children under the age of 15.

CERTIFICATE OF CHILD HEALTH EXAMINATION

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)				**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ • Bridge ☐ • Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian**			
Bone/Joint problem/injury/scoliosis?	Yes No			**Signature**		**Date**	

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _____

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _____

CERTIFICATE OF CHILD HEALTH EXAMINATION (CONT.)

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes		Amblyopia Yes☐ No☐	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Limited ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

STUDENT MEDICAL INFORMATION FORM

Student Medical Information 2015/2016 School Year

INFORMATION MUST BE UPDATED AND SUBMITTED **ANNUALLY** AT THE BEGINNING OF THE SCHOOL YEAR

PLEASE PRINT ALL INFORMATION and RETURN FORM TO SCHOOL

SCHOOL NAME: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Student ID: _____ Medicaid Number: _____

To ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by CPS it is important that the school is aware of any health conditions that may impact your child. We are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff. Thank you for your cooperation in this important matter.

Please check below if applicable:

- ☐ Food Allergies: (Type) _____
- ☐ Other Allergies: (Type) _____
- ☐ Asthma
- ☐ Diabetes: Type 1 ☐ Type 2 ☐
- ☐ Seizures
- ☐ Other Medical Condition

_____

_____

- ☐ My child has **NO** allergies, medical conditions and/or does not take any medications during school hours
- ☐ My child has a primary healthcare provider (e.g., Doctor, Nurse Practitioner, Physician Assistant, etc.)

For the medical condition identified above which requires prescribed medication during school hours, please provide written verification from your healthcare provider with diagnosis, type of medication, dosage, and time to be given. An Emergency Action Plan (Allergy, Asthma, or Diabetes) can also be requested from your healthcare provider. Your child may qualify for a **504 Accommodation Plan** due to his/her condition. Please make sure you follow up with your school nurse and/or case manager once you have submitted this form.

Parent Name: (Please Print): _____ Date: _____

Parent Signature: _____

Phone Number: _____ Email: _____

SECTION 504 TEMPLATE

Dear School Administrator,

Pursuant to Section 504 of the Rehabilitation Act of 1973, I am writing to request an individualized evaluation on behalf of my child, who is diagnosed with asthma, to determine what services and modifications are necessary to include in a 504 Plan. In addition to a 504 evaluation, I am requesting tha the following accommodations be made for my child's health condition while at school and school-sponsored activities:

☐ My child may carry quick-relief asthma medication at all times during school hours and school-sponsored activities.
☐ My child can self-administer quick-relief asthma medication without assistance.
☐ My child's quick-relief asthma medication is to be administered to him/her during school hours.
☐ My child may not be able to participate fully in P.E. activities and may need modified P.E. activities.
☐ My child must be allowed to self-monitor his/her activity level with rest periods as needed, including during P.E. activities.
☐ My child must have early access to the building when temperatures or wind chill are below 25ºF or above 85ºF.
☐ My child cannot participate in outdoor P.E. or other outdoor activities when temperatures or wind chill are below 25ºF or above 85ºF.
☐ My child must have unlimited access to the restroom and access to water for hydration as needed.
☐ My child must be allowed access to the school elevator (if one is available) when necessary due to breathing problems.
☐ My child needs an individual locker.
☐ My child needs an extra set of books for home use.
☐ My child needs intermittent homebound services due to frequent absences.
☐ My child's asthma is triggered by school/classroom conditions and they need to be controlled as follows:
___ All fur/feather bearing pets need to be removed from child's classrooms
___ My child should not sit near the chalkboard
___ My child should not sit near open windows
___ Notify parent/guardian before any dusted or sprayed pesticide application and before any construction or remodeling projects*
☐ **Any Additional Modifications Needed:** _____

I have attached the following documents and am requesting that they be attached to the 504 Plan:

☐ My child's Asthma Action Plan
☐ Medical Provider Documentation
If Self-Administering: ☐ Asthma Prescription Label
☐ Parent Request for Self-Administration of Medication
If *not* Self-Administering: ☐ Physician Request for Administration of Medication to Student
☐ Parent Request for Administration of Medication to Student
☐ Other_____

ILLINOIS HIGH SCHOOL ASSOCIATION

Consent to Self Administer Asthma Medication

As a patient under my care, _____, is prescribed to self-administer the following asthma medication.

Medication_____

Purpose_____

Dosage_____

Time/Special Circumstances_____

_____

_____ _____ _____

Printed Name of Physician Signature of Physician Date

I, _____, do hereby give my son/daughter, _____,
Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

IHSA form for self-administration of asthma medication are **inconsistent** with Illinois Statute 105 ILCS 5/22-30.

CHARTER SCHOOL REPORT

Only 38% of the responding charter schools reported allowing self-administration of asthma inhalers without supervision.

The remaining responding charter schools reported having policies that limit self-administration to "necessary" or "emergency" situations.

HB 1360

Amends the Illinois Charter Schools Law. Requires charter schools to comply with ALL health and safety requirements applicable to public schools

Report Bit Link:
http://bit.ly/1IkDRzw

ADDRESSING ASTHMA EARLY

Don't wait until a child is school-age to develop an Asthma Action Plan.

http://1.usa.gov/1ONE9n5

Problem: Most early care and education programs must have written provisions for emergency medical care, treatment of illness and accidents. No specific requirements for chronic health conditions.

Solution: Asthma Action Plans should be standard in early care and education settings.

NEXT STEPS—ADDRESSING ASTHMA IN SCHOOL AND EARLY CHILDHOOD SETTINGS

What more can be done to improve school and early childhood identification rates?

Asthma Action Plans/504/self-carry and self-administer experiences with schools and early childhood settings?