

Student Name \_\_\_\_\_



DEPARTMENT OF DEFENSE  
DEPENDENTS SCHOOLS  
HEIDELBERG AMERICAN MIDDLE SCHOOL  
UNIT 29237  
APO AE 09102

**MEMORANDUM FOR PARENTS OF STUDENTS WITH ASTHMA/REACTIVE AIRWAY**

SUBJECT: Asthma/Reactive Airway Care Plan

1. The health assessment in your child's school health record indicates that your child has a medical **history of asthma or reactive airway disease**.
2. Please complete the attached forms and return them before your child attends the first day of school. **A healthcare provider must sign the medication permission form.**
2. Medication containers must have a pharmacy label that is clearly marked with:
  - Name of student
  - Name of prescribing health care provider
  - Name of medication
  - Name of Pharmacy
  - Dose and time medication is to be administered
3. If you have any questions, please feel free to call me at your convenience at CIV: 06221-338-9310 or DSN: 388-9310.

I have been informed that my child needs to have the attached asthma/reactive airway care plan completed and signed by a health care provider by the first day that he/she attends school. I understand that if the doctor prescribes medication for asthma/reactive airway, I will provide the health office with a school prescription and the care plan. I understand that without asthma medication, my child will be at risk in an emergency situation. If I do not provide an asthma/reactive airway care plan and medication to the health office, I am responsible for all liability in the event of an emergency and I release the department of defense schools from responsibility.

\_\_\_\_\_ I will provide asthma care plan

\_\_\_\_\_ I decline to provide an asthma/reactive care plan and medication

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**\*\*PLEASE RETURN THIS FORM TO THE HEALTH OFFICE\*\***