Hustisford School District

District Office
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-8109

Jr./Sr. High School
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-3261

John Hustis Elementary
600 S. Hustis. St · P.O. Box 326
Hustisford, WI 53034
(920) 349-3228

Todd Bugnacki
District Administrator

Clint Bushey
Principal

Peter Moe
Principal

Corey Manlick
Director of Financial Services

Alex Pishler
Director of Special Education/Psychologist

Glen Falkenthal
Athletic Director

Asthma Management Medication Orders

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

Triggers of Asthma Episodes:

____ Exercise ____ Allergies ____ Stress _____ Temperature Change
____ Respiratory Infections ____ Animals ____ Smoke _____ Smells/Chemicals

Symptoms of Asthma Episode

____Wheezing ____ Shortness of Breath ____ Cough _____ Other:_____

Scheduled Asthma Medication for School

Medication:_____ Dose:_____ How Often:_____

Emergency/As Needed Asthma Medication for School

Medication:_____ Dose:_____ When to Use:_____

Provider Name: _____ Phone Number: _____
My student has been trained & may self-carry and administer this inhaler: ☐ Yes ☐ No

At the end of the year (circle one): Send medication home with my student/Contact me to pick up

- I authorize this medication/procedure to be administered, potentially by non-medical staff.
- I will supply medication in its original, properly labeled pharmaceutical container
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information with the provider regarding this medication/conditions for which it is prescribed.
- I understand this consent is in effect for the current school year & summer school, school sponsored events & field trips
- I consent to the release of the information contained in this Asthma Emergency Plan to staff members who may need to know this information to maintain my child's health and safety.
- I agree to hold the School District, its employees/ agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicated I have fully read and understood the above information.

Parent Signature: _____ Date: _____

Reviewed 5/2025

The above medication/procedure is to be administered/performed in accordance with the above instructions. I agree to accept communication about student/medication and understand medication may be given by non-medically trained school personnel. My signature indicates I have read and understand the above information. ***This student may self-carry and self-administer medication: Yes/No***

Physician Signature: _____ Date: _____