Asthma Action Plan/ Medication Authorization Form

Name: _____ **DOB:**_____

Doctor: _____ **Date:**_____

Phone for Doctor or Clinic: _____

Predicted/Personal Best Peak Flow Reading:_____

Asthma Triggers

Try to stay away from or control these things:

□ Exercise	□ Smoke, strong odors or spray
□ Mold	□ Colds/Respiratory infections
□ Chalk dust/dust	□ Carpet
□ Pollen/Allergies	□ Change in temperature/weather
□ Animals	□ Dust mites
□ Tobacco smoke	□ Cockroaches
□ Food _____	□ Other _____

1. Green – Go

- Breathing is good.
- No cough or wheeze.
- Can work and play.

Or Peak Flow _____ to _____ (80-100%)

Use these controller medicines every day to keep you in the green zone:

Medicine: How much to take: When to take it: □ Home □ School

_____

_____

5-15 minutes before very active exercise, use □ Albuterol _____ puffs.
□ Other _____ , _____ puffs

2. Yellow – Caution

Coughing

Wheezing

Tight Chest

Wakes up at night

Or Peak Flow _____ to _____ (50-80%)

Keep using controller green zone medicines every day.

Add these medicines to keep an asthma attack from getting bad:

Medicine	How much to take	When to take it
Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ May repeat every 20 min up to 3 doses in first hour, if needed

If symptoms **DO NOT** improve after first hour of treatment, then go to **red zone.**

If symptoms **DO** improve after first hour of treatment, then continue:

Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ Every 4 - 8 hours for _____ days

_____, _____times a day for _____days □ Home
(oral corticosteroid) (how much) □ School

Call your doctor if still having some symptoms for more than 24 hours!

3. Red – Stop – Danger

- Breathing is hard and fast.
- Nose opens wide.
- Can't walk.
- Ribs show.
- Can't talk well.

Or Peak Flow _____ (Less than 50%)

Call your doctor and/or parent/guardian NOW!
Take these medicines until you talk with a doctor or parent/guardian:

Medicine:	How much to take:	When to take it:
Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ May repeat every 20 minutes until you get help

_____, _____times a day for _____days □ Home
(oral corticosteroid) (how much) □ School

Call 911 for severe symptoms, if symptoms don't improve, or you can't reach your doctor and/or parent/guardian.

PHYSICIAN AND PARENT SIGNATURES REQUIRED ON BACK

Student's name: _____ Date of birth: _____

A. TO BE COMPLETED BY MEDICAL PROVIDER:

- I agree with the Asthma Management as written**.**
- I have instructed _____ in the proper way to use his/her inhaled medications. It is my professional opinion that he/she **should** be allowed to carry this medication and administer to himself/herself. This student **will not** need adult supervision when taking this medicine.
- It is my professional opinion that _____ **should not** be allowed to carry his/her inhaled medications or to administer it himself/herself.

Physician Signature: _____ Print Physician Name: _____ Date: _____

ALL MEDICATION ORDERS EXPIRE ON THE LAST DAY OF SCHOOL UNLESS OTHERWISE SPECIFIED: Termination Date: _____

B. PARA SER COMPLETADO POR EL PADRE/ TUTOR

Autorización del Padre para que el nIño se AUTO ADMINISTRE el medicamento

- Estoy de acuerdo con el Plan de manejo del asma escrito por el médico.
- Por la presente, solicito que se autorice a mi hijo a llevar y auto administrarse el inhalador, equipo u otro medicamento recetado en la escuela como ha sido recetado por el proveedor de salud licenciado de mi hijo. Entiendo que mi hijo debe de llevar este medicamento en todo tiempo en la escuela o el/ella perderá el derecho de llevarlo. Entiendo que la escuela no asume ninguna responsabilidad por la administración del medicamento. Por la presente, libero a la Junta Escolar, a sus agentes y empleados, de cualquier y toda responsabilidad que pueda resultar a partir de que mi hijo tome este medicamento. Mi hijo tiene conocimiento de este medicamento y sabe como auto-administrarselo.
- Estoy de acuerdo en asegurar que el inhalador tenga la etiqueta de la farmacia con el nombre de mi hijo/a.

Firma del Padre/Tutor: _____ Teléfono: _____ Fecha: _____

Or

Autorización del Padre para que el medicamento sea administrado por la enfermera/personal escolar

- Estoy de acuerdo con el Plan de Manejo del Asma como está escrito por el médico.
- Por la presente, doy autorización para que mi hijo reciba medicamento durante el horario escolar. Entiendo que la escuela no asume ninguna responsabilidad por la administración de la medicina. Este medicamento ha sido recetado por un proveedor de salud licenciado. . Por la presente libero a la Junta Escolar, sus agentes y empleados, de cualquier y toda responsabilidad a partir de que mi hijo/a tome un medicamento recetado o no recetado. Estoy totalmente de acuerdo en que este medicamento sea administrado cuando sea necesario.
- También estoy de acuerdo en proveer el medicamento con una etiqueta de la farmacia y que si mi hijo va a recibir tratamiento con un nebulizador que yo proveeré la máquina y los tubos necesarios para administrarlo correctamente.

Firma del Padre/ Tutor: _____ Teléfono: _____ Fecha: _____

C. ORDER REVIEWED BY SCHOOL NURSE: _____ DATE: _____

D. STUDENT CONTRACT TO SELF-ADMINISTER MEDICATION

Student Responsibilities:

- I plan to keep my inhaler, equipment, or other medication with me at school. I am capable of taking this medication as recommended and accept this responsibility.
- I agree to use my inhaler, equipment, or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school nurse or teacher/school staff if I am having more difficulty than usual with my asthma.
- I will not share my inhaler, equipment, or other medication with any other person.
- I will carry properly labeled medication with a pharmacy label on my inhaler, or other medication.

Student's Signature: _____ Date: _____

School Nurses Responsibilities:

- Demonstrates correct use and skill level to self-administer
- Recognizes proper and prescribed timing for medication
- Agrees to carry medication or keep in an established location
- Knows health condition well and can identify known triggers and warning signs of asthma symptoms
- I have informed the student that he/she must tell a staff member whenever he/she has used the medication at school.
- Keeps a second labeled container in the health room
- Will not share medication or equipment with others.

School Nurse Signature: _____ Date: _____ revised 08/15kgr