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
- □ Mold
- □ Chalk dust/dust
- □ Pollen/Allergies
- □ Animals
- □ Tobacco smoke
- □ Food _____
- □ Smoke, strong odors or spray
- □ Colds/Respiratory infections
- □ Carpet
- □ Change in temperature/weather
- □ Dust mites
- □ Cockroaches
- □ 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 MEDICATIONS ORDERS EXPIRE ON THE LAST DAY OF SCHOOL UNLESS OTHERWISE SPECIFIED- Termination Date: _____

B. TO BE COMPLETED BY PARENT/GUARDIAN:

Parent Permission for medication to be SELF-ADMINISTERED by their child

- I agree to the Asthma Management Plan as written by the above medical provider.
- I hereby request that my child be allowed to carry and self-administer the inhaler, equipment or other prescription medication at school as prescribed by my child's licensed health care provider. I understand my child must carry this medication at all times in school or he/she will lose the right to carry it. I further understand that the school undertakes no responsibility for the administration of the medication. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking this medication. My child is knowledgeable about this medication and how to self-administer it.
- I agree to ensure that the inhaler will have a pharmacy label with my child's name.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

OR

Parent Permission for medication to be administered by the school nurse/staff

- I agree to the Asthma Management Plan as written by the above medical provider.
- I hereby give my permission for my child to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed health care provider. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking prescription and non-prescription medication. I am in full agreement to supply this medication as needed.
- I also agree to provide the medicine with a pharmacy label and that if my child is to receive nebulizer treatments that I will provide the machine and tubing needed to properly administer it.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

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

D. STUDENT CONTRACT TO SELF-ADMINISTER MEDICATIONS

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