Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for School Year ______________ (including summer school) School#: ________ Grade: ______

Student Name:______________________________ Birth Date: ____________ **Peak Flow Personal Best**:___________

Parent/Guardian's Name:______________________________ Home #:___________ Work #:___________ Cell #:___________

ASTHMA SEVERITY: ❒ Exercise Induced ❒ Intermittent ❒ Mild Persistent ❒ Moderate Persistent ❒ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE

CONTROLLER MEDICATIONS – TO BE USED DAILY AT HOME UNLESS OTHERWISE INDICATED

- ❒ Breathing is good
- ❒ No cough or wheeze
- ❒ Can work, exercise, play
- ❒ Other:________________________
- ❒ Peak flow greater than_______(80% personal best)

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

EXERCISE ZONE

❒ **Prior to exercise/sports/physical education (PE)**

Medication (Rescue Medication)	Dose	Route	Frequency/Time

If using more than twice per week for exercise/ sports/PE notify healthcare provider and parent/guardian

YELLOW ZONE

RESCUE MEDICATIONS – TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

- ❒ Cough or cold symptoms
- ❒ Wheezing
- ❒ Tight chest or shortness of breath
- ❒ Cough at night
- ❒ Other:______________________________
- ❒ Peak flow between________ and ________ (50% - 79% personal best)

Medication	Dose	Route	Frequency/Time
			PRN
			PRN

If symptoms do not improve in _________ minutes, notify healthcare provider and parent/guardian.
If using more than twice per week, notify healthcare provider and parent/guardian.

RED ZONE

EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911

- ❒ Medication is not helping within 15-20 minutes
- ❒ Breathing is hard and fast
- ❒ Nasal flaring or intercostal retractions
- ❒ Lips or fingernails blue
- ❒ Trouble walking or talking
- ❒ Other:______________________________
- ❒ Peak flow greater than______(50% personal best)

Medication	Dose	Route	Frequency/Time

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911

Triggers

- ☐ Chalk dust
- ☐ Cigarette smoke
- ☐ Colds/Flu
- ☐ Dust/Dust mites
- ☐ Stuffed animals
- ☐ Carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests
- ☐ Pets
- ☐ Plants
- ☐ Flowers
- ☐ Cut grass
- ☐ Pollen
- ☐ Strong odors
- ☐ Perfume
- ☐ Cleaning products
- ☐ Sudden change in temperature
- ☐ Wood smoke
- ☐ Foods
- ☐ Other

____
____
____
____
____

HEALTHCARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications: ❒ Yes ❒ No

Healthcare Provider Name: ______________________________

Signature: ______________________________

Office #: ________________

Date: ________________

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child: ❒ is ❒ is not authorized to self-carry his/her medication(s).

Signature: ______________________________

Date: ________________

RECEIVED IN HEALTH SUITE BY________________ DATE______

REVIEWED BY SCHOOL NURSE

Name (Print): ______________________

Signature: ______________________

Date: ______________

Authorized to self-carry medications: ❒ Yes ❒ No