

Asthma Medication Administration Authorization Form ASTHMA ACTION PLAN for

____/____/____ to ____/____/____ (not to exceed 12 months) Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

ASTHMA SEVERITY: Exercise-induced Intermittent Mild Persistent Moderate Persistent Severe Persistent List Triggers: _____

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated				
	<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency
	<input type="checkbox"/> Prior to exercise/sports/ physical education	(Rescue Medication)			
		If using more than twice per week for exercise, notify the health care provider and parent/guardian.			
	YELLOW ZONE: Quick Relief Medications — to be <u>added</u> to Green zone medications for symptoms				
	<input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest or shortness of breath <input type="checkbox"/> Cough at night <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)	Medication	Dose	Route	Frequency
		If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			
RED ZONE: Emergency Medications— Take these medications and <u>call 911</u>					
<input type="checkbox"/> Medication is not helping within 15-20 mins <input type="checkbox"/> Breathing is hard and fast <input type="checkbox"/> Nasal flaring or skin retracts between ribs <input type="checkbox"/> Lips or fingernails blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)	Medication	Dose	Route	Frequency	
	Contact the parent/guardian after calling 911.				

Health Care Provider and Parent Authorization with Review by RN

I authorize the school/camp staff to administer the above medications as indicated. Student may self-carry medications (School-age students only) **Yes** **No**

Prescriber signature & date: _____

Parent/Individual/Guardian signature and date: _____

By signing below, I certify that the student is authorized to self- carry/self-administer medication at school/camp and authorize the student to self-carry/self-administer the medications indicated during school or camp.

Prescriber signature & date: _____

Parent/Individual/Guardian signature: _____

Reviewed by DN/RN Health Supervisor

Name: _____

Signature/date: _____

110216

Prevention Plan

Student's Name: _____ DOB: _____ Room #: _____ Teacher's Name _____

ALLERGY TO: _____

Asthmatic? Y/N) _____ (Yes=Higher Risk for Severe
_____ Reaction)

School will:

- Have a Certified Medication Technician on site with an on-call Delegating RN
- Have staff trained in CPR & First Aid
- Have staff trained in Allergy & Anaphylaxis → administering EpiPen® including demonstration & practice
- Emergency List distributed to: _____
- Have staff trained on individual emergency plans
- School staff will make every reasonable effort to prevent the student's exposure to known allergens
- Other _____

Parents will:

- Provide pertinent health information to the school
- Provide Physician Authorization Forms and Action Plans → for student medication and specific actions plans for emergency care
- Current, non-expired medications
- Provide safe snack option to school/classroom
- Other: _____
- Other: _____
- Other: _____

Student will:

- Make every effort to avoid contact with allergen
- Alert nearest adult if suspect exposure to allergen
- Other

Notes:

