Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for School Year 2020-2021 (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

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

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

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

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

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

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

❒ 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)

EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911

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