Asthma Action Plan/ Medication Authorization Form/School Health

Name: _____ **DOB:**_____ **Teacher:**_____**Grade:**_____

_

Doctor: _____ **Date:**_____ **Parent Name:**_____

Phone for Doctor or Clinic:_____ **Emergency Contact #:**_____

☐ **Self Med** (see physician recommendations on back) Medication will be kept: ☐ class ☐ nurse ☐ book bag

Green - Go

Use these maintenance medications as your doctor advises to keep your asthma symptoms in the green

- Breathing is normal/good.
- No cough, wheeze, chest tightness
- Can work and play without asthma symptoms
- Sleeps well at night

Asthma Severity Classification:
☐ **Intermittent** ☐ **Mild** ☐ **Mild Persistent**
☐ **Moderate Persistent** ☐ **Severe Persistent**

List of Maintenance Medications taken at home ☐ Medications to be given at school ☐ Please indicate below
_____
_____
_____
_____
_____

☐ Please keep the school nurse updated with any medication changes to assist with quality asthma education.

Known asthma triggers:_____

Other – Exercise Related

Use <u>one</u> of these medications <u>before</u> indicated level of activity or condition listed to prevent symptoms during PE/Recess, sports, or outside activities.

Student has asthma symptoms with this level of exercise or condition(s):

- Mild exercise:_____
- Moderate excercise:_____
- Outside activities:_____
- Use only during episodes of asthma flare:_____

☐ **Albuterol MDI 90mcg/1 puff, <u>OR</u>** ☐ _____, give ☐ **2** puffs or, ☐ **4** puffs, inhaled by mouth 5 – 15 minutes **<u>before</u>** indicated level of exercise or condition. ☐ with spacer if provided.

☐ **Nebulized Albuterol 2.5mg/vial** <u>OR</u> ☐ _____, give _____vial(s) inhaled by mouth via nebulizer, 5 – 15 minutes **<u>before</u>** indicated level of exercise or condition.

Other:_____

Yellow - Caution

Use these medications for <u>one or more</u> of the signs and symptoms of a breathing problem!

- Cough
- Wheeze
- Chest tightness
- Problems working or playing due to asthma symptoms
- Waking at night due to asthma
- First sign of a cold

.

☐ **Albuterol MDI 90mcg, <u>OR</u>** ☐ _____, give ☐ 2 puffs or ☐ 4 puffs, inhaled by mouth via inhaler ☐ with spacer if provided. **IF there is no improvement** 20 minutes after taking this rescue medication, then
☐ Repeat the above medication <u>every</u> 20 minutes up to a maximum of _____doses.
OR
☐ **Nebulized Albuterol 2.5 mg/3ml, <u>OR</u>** ☐ _____ give _____Vials inhaled by mouth via nebulizer. If symptoms do not improve in 20 minutes, then ☐ repeat the above nebulized medication x 1.
Other:_____
_____

For continued asthma symptoms, call your medical provider! For worsening asthma symptoms call 911!
Do not leave student alone! Student must be accompanied by an adult until there are improvement of symptoms or medical help is obtained.

Red - Danger

Follow directions in the Yellow Zone for medication use!

- Breathing is hard and fast
- Nostrils are open wide and moving
- Difficulty speaking
- Coughing that is excessive
- Unable to sleep due to breathing issues
- Ribs are noticeable while breathing
- Stomach is moving with breathing
- Drowsy, tired, cannot walk

For <u>continued</u> asthma symptoms, call your medical provider! For worsening asthma symptoms <u>call 911!</u>
<u>Do not leave student alone</u>! Student must be accompanied by an adult until there are improvement of symptoms or medical help is obtained.

Parent/Physician/Nurse: Read and sign back of this page!

Physician's Signature: _____ Date: _____
Physician's Name Printed: _____
All medication orders expire at end of school year unless otherwise indicated:_____
It is recommended by Physician indicated above that student may self-medicate: yes □ or no □
(note: students that self-medicate in grades K – 5, or otherwise indicated, are to consult with school nurse)

Parent permission for medication to be *administered by the school nurse/staff*:

- I hereby give my permission for my child (named above) to receive medication during school hours.
- This medication has been prescribed by a licensed physician.
- I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.
- This consent is good for the school year, unless revoked.
- I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent/Guardian Signature: _____Phone: _____ Date: _____

Parent Permission for medication to be *SELF-ADMINISTERED by their child*: (see contract below)

- I agree to the Medication authorization as written by the above medical provider.
- I hereby request that my child be allowed to carry and self-administer the 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 medication will have a pharmacy label with my child's name.

Parent/Guardian Signature: _____Phone: _____ Date: _____

School Nurse Signature/Order Review:_____ Date:_____

Student Contract for Self-Administered Medication

Student Responsibilities:

- I plan to keep my inhaler, equipment, Epi-pen or other medication with me at school rather than in the school nurse's office.
- I agree to use my inhaler, equipment, Epi-pen or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school health office or main office if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler, equipment, Epi-pen or other medication.
- I will carry the least amount of medication possible in its original container.

Student's Signature: _____ Date: _____

School Nurses Responsibilities:

- Emergency Action Plan complete and on file at school
- Demonstrates correct use/administration
- Recognizes proper and prescribed timing for medication
- Agrees to carry medication or keep in an established location
- Knows health condition well
- Keeps a second labeled container in the health room
- Will not share medication or equipment with others.

School Nurse Contract Signature: _____ Date: _____

Important Information about Medication Use in school

- □ No medication will be given at school until this authorization has been reviewed and signed off by the School Nurse.
- □ Medications are given by a nurse or school staff trained by the School Nurse.
- □ Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- □ Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- □ The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication.
- □ New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.