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

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

Medication	Dose	Route	Frequency

☐ **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

☐ 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

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>

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other:_____
☐ 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/Guardian signature & 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/Guardian signature: _____

Reviewed by DN/RN Health Supervisor

Name: _____

Signature/date: _____

_____

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Asthma Action Plan School/Parent/Student Checklist

Student Name: _____ Date of Birth: _____

Teacher Name: _____ Room #: _____

School Will:

- ☐ Have a Certified Medication Technician (CMT) on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Asthma Signs & Symptoms and Administration of Inhaler or Nebulizer
- ☐ Have Emergency List distributed to all school staff
- ☐ Have staff trained on Individual Specific Student Emergency Plans
- ☐ Make every reasonable effort to prevent the student's exposure to known allergens and Asthma triggers
- ☐ Other _____

Parents Will:

- ☐ Provide pertinent health information to the school
- ☐ Provide current Physician Medication Authorization Form(s) and Asthma Action Plan
- ☐ Provide current, non-expired medication(s)
- ☐ Provide spacer if indicated, as needed by physician
- ☐ Other: _____
- ☐ Other: _____

Student Will:

- ☐ Come to office to use inhaler prior to exercise
- ☐ Alert nearest adult if they experience any symptoms of Asthma
    - Cough
    - Wheezing
    - Shortness of breath
    - Chest tightness
- ☐ If self-carrying and self-administering their inhaler:
    - Demonstrate responsibility by carrying their inhaler
    - Notify adult when needed and before using
    - Commit to not sharing medication with any other person

Notes:

Medication Form/Physician's Order (To be Completed by the Physician/Authorized Health Care Provider)

School: _____ Grade: ____ Date of Order: _____ Order Expires End of School Year or (date): _____

Student Name: _____ Order valid for current year/Summer (check if appropriate) ☐

DOB: _____ Gender: M F Allergies: _____

Name of Medication: _____ Dose: _____ Route: _____ Time to Give Medication: _____

Reason for Medication: _____ Frequency of Medication (IF PRN):_____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

Parent/Guardian Name:	**Physician Name:**	**Phone:**
Phone:	**Address:**	
PARENT SIGNATURE:	**PRESCRIBER SIGNATURE:**	

Medication Administration Record (For School/Camp Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Name/Position Initials Name/Position Initials

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

RN Signature: _____ **Date:** _____

CODES: Chart Reason (see H.S. Manual)

X: School Closed FT: Field Trip

A: Absent: R: Refused

N: None Available O: Omitted

NS: No Show to HR H: Dose Held

D/C: Med. Discontinued

L/E: Late Arrival/Early Dismissal

Medication Administered (This side for school use only)

Student Name:

Date	Time	Student Complaint	R.N. Consulted ✓	Medication Administered as Ordered ✓	Student Outcome	Staff Initials	Parent Notified ✓

Comments: