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/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: _____

_____

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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:

_____

_____