HERRON HIGH SCHOOL
HERRON-RIVERSIDE HIGH SCHOOL
HERRON PREPARATORY ACADEMY

ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

PARENT/GUARDIAN: Complete and Sign this portion and the medication authorization below		Today's Date:
Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	

① **KNOWN ASTHMA TRIGGERS**: □ Exercise □ Pet Dander □ Mold □ Dust □ Pollen □ Colds □ Strong Odors □ Cold Air □ Pests

② **ALLERGIES:** ______________________________

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS BELOW, SIGN AND DATE. THANK YOU!
Asthma Medication(S) To Be Given:

Student's Asthma Severity Classification: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

Ⓐ Exercise Pre-treatment: □ Not Required □ Before Recess □ Before PE/Sports

Give: Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) □ **10-15 minutes before exercise** □ **with spacer**

(***Circle One***)

Nebulized Albuterol 2.5mg/Xopenex 0.63mg _____ Vial inhaled (by mouth) □ **10-15 minutes before exercise** □ **with nebulizer**

OTHER: ____

Ⓑ RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING
(Follow CAUTION or DANGER ZONES of Asthma Action Plan)

Give (***Circle One***):

Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) □ **every ___ hours** □ **with spacer**

Nebulized Albuterol 2.5mg OR _____ Vial inhaled (by mouth) □ **every ___ hours** □ **nebulizer**
Nebulized Xopenex 0.63mg

OTHER: ____

*** If there is no improvement 20 minutes after taking the Rescue Medication: Notify provider**

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a

③ **Side Effect(s) to watch for:** Nervousness, Shaking, Palpitations, Headache ______________________**or** □ **None**

④ **Reaction to/or negative interaction with food or drugs:** ______________________________ **or** □ **None**

⑤ **Self–Administration Authorization:** ☐ This student **is** capable to safely and properly self-administer medication(s)

OR ☐ This student **is not** approved to self-administer medication(s)

⑥ **Medication Start/End Dates (one year max)**
Start: _____/_____/____ **End:** ___/____/____

Health Care Provider's Signature: _________________________ **Date:** ________ **Phone #** ____________

(ADD STAMP with Address and Phone ____

PARENT/GUARDIAN CONSENT:

- ☐ I authorize the student to possess and self-administer medication as described and directed above
- ☐ I authorize this medication to be administered by school personnel as described and directed above
- ☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- ☐ I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- ☐ I assume full responsibility for providing the school with the prescribed medication and spacer.
- ☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent Signature: ________________________________ **Date:** ______________________

Name of Individual Receiving Written Authorization and Medication ______________________________ Title/Position: ____________
(PRINT & SIGN)

Nurse (if applicable):______________________________

Note: This form is a sample in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v).

Asthma Action Plan & Medication Authorization

GO ZONE – You're Doing Well! TAKE THESE MEDICINES EVERYDAY

If you have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep well at night
- Can work and play

CONTROLLER MEDICINE (Dose/Route)	HOW MUCH	HOW OFTEN	WHEN
1. ____________________	________ Puffs Inhaled □ **with spacer**	________	**AM/PM**
2. ____________________	________	________	**AM/PM**
3. ____________________	________	________	**AM/PM**
4. ____________________	________	________	**AM/PM**

CAUTION ZONE: – SLOW DOWN ! CONTINUE WITH EVERYDAY MEDICINE and ADD RESCUE MEDICINE

If you have *any* of these:
- First signs of a cold
- Exposed to known Trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

DO THIS: Give (***Circle One***):

Albuterol MDI 90 or Xopenex MDI 45 ____ Puffs Inhaled (by mouth) □ **every** ___ **hours** □ **with spacer**

Nebulized Albuterol 2.5mg
OR Nebulized Xopenex 0.63mg ____ Vial inhaled (by mouth) □ **every** ___ **hours** □ **nebulizer**

*CALL YOUR HEALTH PROVIDER IF:

- ➢ **There is no improvement 20 minutes after taking the Rescue Medication**

Nurse: Call parent and/or provider if using Rescue medication more than 2 days/week for asthma symptoms or for control concerns

DANGER ZONE – GET HELP! TAKE THESE MEDICINES AND CALL YOUR PROVIDER NOW

If your Asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous

MEDICINE *(Circle med)*	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90 / Xopenex MDI 45	________ Puffs Inhaled □ **with spacer**	**NOW!**
2 .Nebulized Albuterol 2.5mg/Xopenex 0.63mg	________ 1 vial inhaled	**NOW!**

***Call your Health Care Provider NOW, if they are not available,**
Go to the emergency room or call 911 and bring this form with you.
DO NOT WAIT!

Parent/Guardian: Make an appointment with your health care provider within 2 days of an ED visit, hospitalization, or anytime for ANY problem or question

____
Prescriber Signature Date

____
Parent/Guardian Signature Date

____
Nurse Date