Centerville City Schools

ASTHMA ACTION PLAN/INHALED ASTHMA MEDICATION AUTHORIZATION

(In accordance with ORC 3313.713/3313.716)

Student Information *(Please print)*

Name:	Birth Date:	Place Student Picture Here
Student Address:	Phone:	
School:	Grade/Teacher:	

Parent/Guardian Authorization (All parents to complete)

1. As the Parent / Guardian of this student: I authorize an employee of the school board to administer the prescribed medication at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
2. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
3. I also authorize Centerville City School's registered nurse to talk with the prescriber or pharmacist to clarify medication order.
4. I give permission for this information to be sent to the school via facsimile.
5. Medication can only be accepted by a Centerville City School's nurse **and** with the appropriately completed medication form.
6. I understand that the medication must be in the ***original*** container and be properly labeled with the students name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration.

Please contact parent/guardian if____

Parent/Guardian Name:	Phone #1:	Phone #2:
Parent/Guardian Signature:	Date:	

Parent/Guardian Self-Carry Authorization (Only complete if student is going to self-carry)

1. As the Parent/Guardian of this student: **I authorize** my child to possess and self-administer an inhaled asthma medication, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
2. **Please consider providing a backup inhaler for the school clinic.**
3. As the Parent/Guardian of this student: I understand that if this medication is self-administered, and the student does not get expected relief, the student must notify a staff member who will facilitate notifying the registered nurse.

Parent/Guardian Signature:	Date:

Special considerations and precautions for school activities, sports, field trips:

1. Staff member in charge of the school sponsored event will be trained by the *school's registered nurse* in the administration of multi dose inhaler (MDI).
2. The medication will be provided to the staff member for safe storage *in locked medication bag* with precautions that the inhaler will be kept at room temperature (59-86 degrees), out of extreme cold and heat, and kept away from moisture or direct sunlight.
3. Staff members must have access to a phone.

Bus Precautions:

If quick relief medication is not available and the student requires treatment, driver will pull over and call 911.

Routine Home Asthma Medications (parent please complete)

Medication Name	Dose	When Taken
1.____________________	__________	____________________
2.____________________	__________	____________________
3.____________________	__________	____________________

*****MUST HAVE MEDICATION AUTHORIZATION FORM ON BACK COMPLETED BY PHYSICIAN *****

MEDICATION ORDERS

Name______________________________________ DOB: __________________ ID/Grade ___________________

Severity Classification - Check one	**Triggers** - Check known triggers	**Any Exercise Modifications Needed?**
___ Mild intermittent ___Moderate persistent ___Mild persistent ___Severe persistent	___Illness ___Exercise ___Strong emotions ___Dust ___Pollen ___Strong odors/spray ___Mold ___Animals ___Weather Changes ___Stress ___Smoke ___Extreme (hot/cold) ___Ozone alert days ___Foods___________________________ ___Other___________________________	List___________________________ ______________________________ ______________________________

Medications

A. QUICK-RELIEF Medication Name MDI or neb? Dosage/Frequency

1. ____________________________ _____________ ___________________________________

2. ____________________________ _____________ ___________________________________

B. 5-15 min. BEFORE PE or EXERTION MDI or neb? Dosage/Frequency

1. ____________________________ _____________ ___________________________________

GREEN ZONE Peak Flow ______________________ Treatment - None

Breathing is good, No cough or wheeze

YELLOW ZONE Peak Flow __________ to ___________ Treatment - Give QUICK RELIEF medicine

Coughing, chest feels tight
Wheezing, feel short of breath

Call parent
If no improvement, go to RED ZONE

RED ZONE MEDICAL ALERT Peak Flow ______ to ______Treatment–Give QUICK RELIEF medicine, CALL 911

Breathing is hard and fast
Trouble walking or talking
Nose wide open, ribs show

CALL PARENT
Repeat QUICK RELIEF medicine in 15 to 20 minutes if help has not arrived

Date administration to begin: ______________________ Date administration to end: _______________________

Adverse Reactions that should be reported to physician:

For the student for which it is prescribed: ____

For the student for which it is NOT prescribed:____

Self-Administer Authorization from Physician – check appropriate authorization

_______ As the prescriber I have determined that this student is capable of possessing and self-administering this inhaled asthma medication appropriately and have provided the student with training in the proper use of the inhaler.

_______ As the prescriber, I have determined that this student **is not capable** of possessing and using this inhaled asthma medication appropriately and this medication should be administered by trained school personnel.

Prescriber Name _______________________________________Phone Number_________________________________

Prescriber Signature _________________________________Date ____________ Emergency Number_______________

***** ORDERS MUST BE RENEWED EVERY SCHOOL YEAR *****