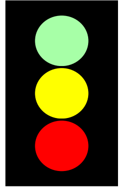
Asthma Action Plan & School Medication Authorization



Name:	DOB:	Date:
Important! Things that make your asthma worse (Triggers): □ smoke □ pets □mold □dust-mites □pollen/trees □colds/viruses □exercise □seasons: other:		

Severity Classification: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

GO ZONE – You're Doing Well!

USE THESE **MEDICINES EVERYDAY** TO PREVENT SYMPTOMS

If you have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

CAUTION ZONE – Slow Down!

CONTINUE WITH GO ZONE MEDICINE and ADD:

If you have *any* of these:

- First signs of a cold
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

School Nurse: Call parent or provider if using PRN 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

HEALTH CARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR Albuterol as stated in above plan, and in accordance with CT State Law and Regulations 10-212a * Not to exceed **6 puffs** within regular school hrs (6hrs), without notifying provider **Office Stamp**

Side effects: ☐Not expected, or ________________________________ Medication Allergies:☐ NKDA, or ________________________

Self–Administration: ☐This student **is** capable to safely and properly self-administer this medication **OR**
☐This student **is not** approved to self-administer this medication

Signature: Date: Duration: One school year /365 days

Parent/Guardian Consent: REQUIRED

☐ I authorize the student to **possess** and **self-administer** medication **OR** ☐ I authorize this medication to be **administered by school personnel**

➢ I authorize exchange of information between the prescribing health care provider and school nurse to ensure the safe administration of this medication plan

Signature: Date: *** Bring asthma meds and spacer to all visits**

Nurse Signature Date: Acknowledges review of Medication Plan