**School Asthma Medication Administration Authorization Form**

**ASTHMA ACTION PLAN** _____/_____/_____ to _____/_____/_____ (not to exceed 12 months)
Date Date

Trigger (LIST)
_____
_____
_____
_____

Child's Name: _____ DOB: _____ Peak Flow Personal Best: _____

Parent/Guardian's Name: _____ Home: _____ Work: _____ Cell: _____

**ASTHMA SEVERITY**: ❑ Exercise Induced ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

**CHECK SYMPTOMS / INDICATIONS FOR MEDICATION USE**

## GREEN ZONE
- ❑ Breathing is good
- ❑ No cough or wheeze
- ❑ Can work, exercise, play
- ❑ Other: _____
- ❑ Peak flow greater than: _____ (80% personal best)

## YELLOW ZONE
- ❑ Cough or cold symptoms
- ❑ Wheezing
- ❑ Tight chest or shortness of breath
- ❑ Cough at night
- ❑ Other: _____
- ❑ Peak flow between: _____ and _____ (50%-79% personal best)

## RED ZONE
- ❑ Medication is not helping within 15-20 mins.
- ❑ Breathing is hard and fast
- ❑ Nasal flaring or intercostal retraction
- ❑ Lips or fingernails blue
- ❑ Trouble walking or talking
- ❑ Other: _____
- ❑ Peak flow less than: _____ (50% personal best)

## CONTROLLER MEDICATION – USE DAILY AT HOME LESS OTHERWISE INDICATED

| Medication | Dose | Route | Frequency/Time |
|---|---|---|---|
| | | | ❑ School |
| | | | ❑ School |
| | | | ❑ School |

## EXERCISE ZONE

❑ Prior to exercise/sports/physical education (PE)

| Medication (Rescue Medication) | Dose | Route | Frequency/Time |
|---|---|---|---|
| | | | |

*If using more than twice per week for exercise/sports/PE, notify the health care provider and parent/guardian.*

## RESCUE MEDICATIONS – TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

| Medication | Dose | Route | Frequency/Time |
|---|---|---|---|
| | | | |
| | | | |

➔***Physician, please note:*** *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.*

## EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911

| Medication | Dose | Route | Frequency/Time |
|---|---|---|---|
| | | | |
| | | | |

*CONTACT PARENT/GUARDIAN AFTER CALLING 911*

## HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above. ❑ Yes ❑ No Student may self-carry. ❑ Yes ❑ No

Health Care Provider Name: _____ Phone Number: _____

Health Care Provider Signature: _____ Date: _____

## PARENT/GUARDIAN AUTHORIZATION

I agree with the administration of the above-ordered medication and authorize the school RN/LPN to communicate with the health care provider as allowed by HIPPA. ❑ Yes ❑ No

I understand the requirements and request that my child self-carry his/her medication. ❑ Yes ❑ No

Parent/Guardian Signature: _____ Date: _____

## REVIEWED AND APPROVED BY SCHOOL RN/LPN

Student may self-carry his/her medication. ❑ Yes ❑ No

School RN/LPN Signature: _____ Date: _____