MEDICAL AUTHORIZATION FOR ASTHMA Management AT SCHOOL

Student:_________________________________ Birth Date:______________________Grade: ________

Parent Section *Seccion des Padres*	**I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. I understand that this information will be shared with school staff on a "need to know" basis. The school nurse may contact the healthcare provider to discuss/clarify this order as needed. I also understand that expired medications will be properly disposed of by the school nurse unless otherwise requested**. *Yo pido que la enfermera o personal designado le adminstre el medicamento recetado de acuerdo con las instrucciones del medico. Yo entiendo que cualquier infomacion de este formulario sera comunicada al personal escolar que necesite estar informado. La enfermera escolar puede comunicarse el profesional de la salud para discutir /aclarar este orden, según sea necesario. También entiendo que los medicamentos expirados estarán adecuadamente desechados por la enfermera de la escuela, a menos que los solicite.* **I give permission for the nurse to initiate a 504 Plan.** Yes/*si* No *Yo doy permiso para la enfermera de inciciar un plan 504* **I give permission for my child to carry this medication.** Yes/*si* No *Doy permiso para que mi estudiante pueda cargar su medicamento.* **I give permission for my child to self-administer this medication.** Yes/*si* No *Doy permiso para que mi estudiante pueda administrarse su propio medicamento.* *Signature/Firma* *Date/Fecha* *Phone #1/Numeros de telefonos* *Phone #2*

---------------------***LICENSED Health Care Provider to Complete Section Below***---------------------------------

Asthma Severity: Intermittent Persistent: Mild Moderate Severe

Home Controller Medications______________________________Student's Asthma Triggers___________________________________

Usual Symptoms____

Student also has severe allergy? No Yes To What?____

QUICK RELIEF MEDICATION ORDERS (check all that apply) **SPACER**: Yes No

- ❏ Albuterol (ProAir®, Ventolin®, Proventil®) 2 puffs as needed every 4 hours for cough/wheeze/chest tightness/difficulty breathing
- ❏ Albuterol Unit Dose per nebulizer every 4 to 6 hours as needed for cough/wheeze/chest tightness/difficulty breathing
- ❏ Levalbuterol (Xopenex®) 2 puffs as needed every 4 hours for cough/wheeze/chest tightness/difficulty breathing

Other:____

Medication side effects: restlessness, irritability, nervousness, rarely tremor, increased or Irregular heart rate

YELLOW ZONE: Asthma symptoms *(cough, wheeze, chest tightness, difficulty breathing)*

Give _______ puffs quick-relief inhaler. If symptoms persist, repeat after 5-10 minutes.

If no improvement after repeated dose follow Red Zone instructions below

May administer quick relief inhaler every ________ hours prn

Until symptoms resolve, restrict strenuous physical activity

RED ZONE: Severe symptoms *(very short of breath, ribs visible during breathing, trouble walking or talking, color poor)*

Do NOT leave student unattended

Give 4 to ______puffs quick-relief inhaler. If symptoms persist repeat after 5-10 min.

Give Epi auto-injector 0.3 mg Give Epi Jr. auto-injector 0.15 mg NO Epinephrine

CALL 911 if: no relief or still in red zone 15 min after using inhaler or if lips or fingernails are blue

EXERCISE PRETREATMENT Yes No (circle all that apply)

Give 2 to _____ puffs quick-relief inhaler 15-30 minutes prior to: **PE** **Recess** **Sports** Consistently @______am/pm **OR** PRN

Pretreatment should not be given more often than every _____ hours.

May repeat _______ puffs of quick-relief inhaler **if symptoms occur** during activity.

Medication order is valid for duration of current school year (which includes summer school)

This student may carry this emergency medication at school. Yes No

This student is trained and capable of self-administering this emergency medication. Yes No

Licensed Health Care Provider Signature *Printed LHCP Name*

Date *Health care provider phone* *Health care provider FAX*

April 2022