E2: Asthma Medication Order

Revised 05/2021

Name:	Birthdate:
Is ASTHMA considered ☐ **Exercise Induced** ☐ **Mild** ☐ **Moderate** ☐ **Severe**	

ALL SECTIONS ON THIS PAGE TO BE COMPLETED BY STUDENT'S LICENSED HEALTHCARE PROVIDER (LHP):

Asthma / Triggers: ☐ None known ☐ Animals ☐ Cold air ☐ Exercise ☐ Pollens ☐ Respiratory colds (i.e., foods, emotions, insects, etc.)
☐ Smoke, chemicals, strong odors ☐ Other _____

USUAL ASTHMA SYMPTOMS:
☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asking to use inhaler ☐ Other _____

QUICK RELIEF MEDICATION ORDERS: (check the appropriate quick relief med(s))
☐ Uses inhaler with spacer ☐ Albuterol 2 puffs (Proair®, Ventolin HFA®, Proventil®) as needed every 4 hours for cough/wheeze
☐ Levalbuterol 2 puffs (Xopenex®) as needed every 4 hours for cough/wheeze

☐ Other _____ Epi auto-injector ☐ 0.3 mg ☐ Jr. 0.15 mg Dose: _____ Time: _____

☐ **Daily controller meds:** _____ ☐ Takes daily controller medications at school

☐ Takes daily controller medications at home

SIDE EFFECTS of medication(s): _____
This student demonstrated correct use of the inhaler in the LHP's office as required.

This student is able to carry and use inhalers. ☐ **YES** ☐ **NO**

YELLOW ZONE **SIGNIFICANT SYMPTOMS** **DO NOT LEAVE STUDENT UNATTENDED**

▶ If student is using quick relief inhaler > 2 times a week or requires frequent observation by school staff ➔ **Notify parents + nurse**

▶ If student is coughing, wheezing and having difficulty breathing:

☐ Give 2 puffs of quick relief inhaler. May repeat in 5-10 minutes. ➔**Notify parents + nurse if repeated.** ☐ Other: _____

▶ **If NO improvement after repeated dose, call 911 – See below.**

RED ZONE **CALL 911** **DO NOT LEAVE STUDENT UNATTENDED**

If student is very short of breath, can see ribs during breathing, difficulty walking to talking, blue appearance to lips or nails, quick relief medication not working.

▶ **Call 911** ☐ Give 4 puffs quick relief inhaler (or nebulizer treatment) and notify parents and school nurse.
☐ This student needs Epi auto-injector for severe asthma attacks ☐ May carry and self-administer Epi auto-injector
☐ Needs help giving the Epi auto-injector. ☐ Other: _____

EXERCISE PRE-TREATMENT ORDERS (check all that apply) ☐ **N/A**

☐ Give 2 puffs of quick relief inhaler 15-30 minutes prior to: ☐ **PE** ☐ **Recess** ☐ **As needed**

With no less than 2 hours between doses unless student complains of symptoms.

☐ May repeat 2 puffs of quick relief inhaler in symptom occur. ➔ **Notify parents + nurse if repeated.**

LHP Signature:		Print name:
Start date:	End date: (not to exceed current school year)	☐ Last day of school ☐ Other:
Date:	Telephone:	Fax:

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e.: doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHP/medical office staff about his medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.
- Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
  - I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No
  - This permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer.

Parent/Guardian Signature: _____ **Date:** _____

For District Nurse's Use Only Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication.	Device(s) if any, used: _____ Expiration date(s): _____ School Nurse Signature: _____ Date: _____