MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

Pasco School District Fax# _____

Student:_____Birth Date:_____ Grade:_____

Parent Section *Sección de Padres*

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions. I understand that this information will be shared with school staff on a "need to know" basis.
Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del medico. Yo entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.

I give permission for my child to carry this medication. ☐ Yes/*sí* ☐ No
Doy permiso para que mi hijo/hija pueda cargar su medicamento.

I give permission for my child to self-administer this medication. ☐ Yes/*sí* ☐ No
Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.

_____ _____ _____ _____
Signature/Firma *Date/Fecha* *Phone #1* *Números de teléfonos* *Phone #2*

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW

Asthma Severity ☐ Intermittent ☐ Persistent: ☐ Mild ☐ Moderate ☐ Severe
Usual Symptoms _____
Student's Asthma Triggers_____
Home Controller Medications_____

Any severe allergy? ☐ No ☐ Yes To What?_____

QUICK RELIEF MEDICATION ORDERS **SPACER** ☐Yes ☐No
☐ Albuterol (ProAir®, Ventolin®, Proventil®)
☐ Levalbuterol (Xopenex®)

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 but give no more than _____additional puffs of the inhaler

☐ 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)***

CALL 911 and School Nurse if available and do not leave student unattended

☐ Give 4 to _____ puffs quick-relief inhaler ☐ If symptoms persist repeat after 5 - 10 minutes
☐ Give Epi auto-injector 0.3 mg ☐ Give Epi Jr. auto-injector 0.15 mg ☐ NO Epinephrine

EXERCISE PRETREATMENT ☐ Yes ☐ No (If yes, check all that apply)

☐ Give 2 to _____ puffs quick-relief inhaler 15-30 minutes prior to ☐ PE ☐ Recess ☐ Sports
☐ Consistently **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
School Nurse approves self-carry and self-adminstration for this student. ☐ Yes ☐ No

_____ _____
Licensed Health Care Provider Signature *Printed LHCP Name*

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

May, 2014