

MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

Okanogan School District

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

Licensed Health Care Provider Signature

Printed LHCP Name

Date

Health care provider phone

Health care provider FAX

ASTHMA INFORMATION FOR SCHOOL

Please complete and return to School Office

The following will assist the school nurse to determine if any special needs will be required for your child while at school. If you desire a conference with the school nurse, please call for an appointment.

Student Name: _____ Date of Birth: _____

School: _____ Grade/Teacher: _____

Parent/Guardian: _____ Phone: _____

Physician treating Asthma: _____ Phone: _____

1. How long has your child had asthma?
2. Do you expect asthma to be a problem for your child while at school?

3. How many times in the past year has your child:
 - Missed school due to asthma? Number of days _____
 - Been seen in the emergency room for asthma? Number of times _____
 - Stayed overnight in the hospital? Number of times _____

4. What triggers your child's asthma? (circle all that apply)

Exercise	Animals	Molds
Colds and infections	Dust	Other:
Weather changes	Foods :	
Pollens	Emotional stress	

5. What are the early warning signs of an asthma episode? (circle all that apply)

Coughing	Tired	Shoulders raised
Wheezing	Irritable	Short of breath
Other:		

6. Does your child understand asthma triggers and reliably report any difficulty? ____YES ____NO
7. Does your child use a peak flow meter at home? ____YES ____NO
Will you be supplying a peak flow meter at school? ____YES ____NO
8. Please list medications your child takes at home and at school. Circle the ones you think your child will need to have at school:

Please ask your physician to complete and sign a Medication Authorization form for any medications to be given while the student is at school. You should also sign the form and bring to the school office.

Thank you for your assistance.

Parent/Guardian Signature: _____ Date: _____

INFORMACION DE ASMA PARA LA ESCUELA

Por favor complete y regrese este formato a la oficina de la Escuela

La siguiente información le ayudará a la enfermera a determinar si su niño/a tiene alguna necesidad especial durante el año escolar. Si usted desea tener una plática con la enfermera de la escuela, por favor llame para hacer una cita.

Estudiante: _____ Fecha de Nacimiento: _____

Escuela: _____ Grado/Maestra/o: _____

Padre/Guardián _____ Teléfono: _____

Doctor que atiende el Asma: _____ Teléfono: _____

1. Por cuanto tiempo ha tenido su niño/a asma?
2. Usted cree que el asma será un problema para su niño mientras este en la escuela?
3. Cuantas veces el año pasado su niño?:
 - No asistió a la escuela por causa del asma? Numero de días _____
 - Fue llevado al cuarto de emergencias por el asma? Cuantas veces _____
 - Estuvo hospitalizado? Cuantas veces _____

4. Que le provoca a su niño el asma? (circule todos los que aplican)

Ejercicio	Animales	Humedad/moho
Resfriados o infecciones	Polvo	Otros:
Cambios de tiempo	Comidas:	
Polen	Estrés-emocional	

5. Cuales son los primeros síntomas de un episodio de asma? (circule todos los que aplican)

Toser	Cansado	Hombros levantados
Dificultad al respirar	Irritable	Falta de respiración
Otros:		

6. Sabe su hijo que le provoca el asma y reporta cualquier dificultad? ____SI ____NO
7. Utiliza su niño un aparato para medir su respiración en la casa? ____SI ____NO
Usted proporcionara uno de esos aparatos para que él tenga en la escuela? ____SI ____NO
8. Haga una lista de los medicamentos que su niño/a toma en la casa y en la escuela. Circule los que usted cree que necesita tener en la escuela.

Pídale a su doctor que complete y firme una autorización de cada medicamento que su niño debe tomar en la escuela. Usted también debe firmar el papel y traerlo a la oficina de la escuela. Gracias por su ayuda.

Firma del Padre/Guardián: _____ Date: _____