Owasso Public Schools

Inhaled Asthma Medication Administration

____________________________ ________________ __________________

Student's Name DOB Grade/Teacher

To Be Completed by Parent/Legal Guardian

I,________________________________, the parent or legal guardian of _____________________________(“Student”) acknowledge that I have read and understand the Inhaled Asthma Medication Administration guidelines, and I agree to abide by the guidelines at all times. I understand that OPS and its employees, agents, and representatives, shall incur no liability as a result of any injury or issue arising from the self-administration of medication by my student. Furthermore:

- ☐ My student is capable of deciding if he/she is able to resume school activities. If my student states that he/she is unable to resume activities, call one of my emergency contacts to pick up my child.
- ☐ Notify one of my emergency contacts to pick up my student.
- ☐ Other(specify) ____

Parent/Guardian's Signature: _______________________________________ Date: ______________________

To Be Completed by Physician

Student's Name: ____ Diagnosis:___________________________

Medication Order (note the interval for repetition of the dose if p.r.n.): ____

____

Side Effects to Expect: ____

Please check one of the following options:

- ☐ In my professional opinion, it is medically necessary that this student be allowed to self-carry and self-administer the above medication. I verify this student has the knowledge and ability to safely administer and safeguard this medication, and the student can assess whether or not they are able resume activities without being assessed by a nurse.
- ☐ I authorize this medication to be administered by a RN. In the event that a nurse is not available, I authorize this student to self-administer the above medication and receive assistance from a designated school representative, if needed. I verify that this student has the knowledge and ability to safely administer this medication.

Physician's Name: ____ Phone Number: ________________

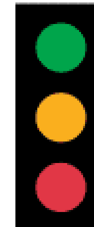
Physician's Signature:____ Date: _________________________

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: ________________

GO

Use these daily preventive anti-inflammatory medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow: from ______ to ______

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow: from ______ to ______

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR PRIMARY CARE PROVIDER.		

DANGER

Take these medicines and call your doctor now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow: reading below ______

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.