School Year_______________

Elder Grove School Asthma/Quick Relief Bronchodilator Medication Authorization

Student Name:___________________________ Date of Birth:____________ Grade: _____

Known Triggers	❏ Exercise	❏ Upper Respiratory Infection	❏ Other________________

HEALTH CARE PROVIDER

Is student is diagnosed with asthma or reactive airway disease Yes _____ No _____

Any ER visits or hospitalization for asthma in the last 1-2 years Yes _____ No _____

Order is valid through the end of the school year unless stated otherwise: Other length_______

PREVENTATIVE: Pre-treatment with medication and dose named below before strenuous activity:

_____ Not needed _____ Routinely _____ Upon Request (ex. Weather, viral season)

_____ May be repeated in 4 hours if needed for additional or ongoing physical activity

MILD TO MODERATE SYMPTOMS:

- ❏ For asthma/difficulty breathing symptoms: use this quick acting medication:
  - ❏ Albuterol (Proventil, Pro-Air & Ventolin) ___ 1 puff ___2 puffs ___ Other dose

- ❏ If symptoms return within a few hours, repeat the above medication order and notify the parent.
- ❏ If symptoms continue but are not severe, repeat again after 20 minutes and notify the parent.

SEVERE SYMPTOMS: Ex: continual coughing, struggling to breath, trouble talking

____ 2 Puffs ____4 Puffs ___ Other Dose/Med Medication name/Dose:________________

- ❏ Call 911 then school nurse if available and parent
- ❏ Repeat above dose for severe symptoms if EMS has not arrived in 10 minutes

- ❏ Permission for the student to self administer. I confirm this student has been instructed in the proper use of the medication (s) listed above and is able to self-administer without school personnel supervision.
- ❏ Permission **is not given** for the student to self administer without supervision.

Other comments per Provider:

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Printed name___________________________Provider Signature:______________________

Phone ________________________________ Date_________________________________

THIS FORM MUST BE COMPLETED AND FAXED BACK TO SCHOOL PRIOR TO MEDICATION GIVEN. Elementary: 406-651-4346. Middle: 406-656-7398

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School nurse signature: _____________________________ Date reviewed: __________