Asthma Physician Orders and Student Health Plan

Name of Student ____ Date of Birth ______________ Grade _________
Parent/Guardian ____ Phone ________________ Phone____________
Emergency Contact ____________________________________ Relationship ________________ Phone ___________

Parent/Guardian Authorization: I authorize LESD to administer the prescribed medication ordered by my health care provider. I will provide the medication and equipment in the original pharmacy-labeled container. I approve the health plan as written. **Signature of parent/guardian:**____

HEALTH CARE PROVIDER TO COMPLETE ALL SECTIONS BELOW

Medication Ordered for Quick Relief (Rescue)

☐ Albuterol inhaler & Spacer
☐ Other med ______________________
☐ Student needs assistance with medication
☐ MIDDLE SCHOOL ONLY: Student has been instructed by Doctor and may be allowed to self-carry and self-administer medication

Student has the following triggers: ☐ Exercise ☐ Weather ☐ Smoke ☐ Illness ☐ Dog/Cat ☐ Mold ☐ Pollen
☐ Other:____

☐ Student also has allergies to: _______________________

GREEN ZONE-----BREATHING IS GOOD AND EASY

Give ____ puffs Quick Relief/Rescue 15 minutes before: ☐ PE/Exercise/Sports PRN ☐ Recess PRN ☐ Other______
May repeat ____ puffs every ____ hours, if needed for additional or ongoing activity.

YELLOW ZONE----BREATHING IS GETTING WORSE

If you see this:

- Difficulty breathing
- Wheezing
- Frequent cough
- Complains of chest tightness
- Unable to tolerate regular activities
- Other:

Do this:

1. Stop physical activity.
2. **Give____ puffs Quick Relief/Rescue medication.**
3. If student improves to normal, student may return to normal activity.
4. **If not improved in 10-15 minutes, repeat _____ puffs of rescue medication.**
5. Always call parent and school nurse if student does not improve

RED ZONE----EMERGENCY SITUATION

If you see this:

- Coughs constantly
- Struggles or gasps for breath
- Trouble talking
- Skin of chest and/or neck pull while breathing
- Lips or fingernails are grey or blue
- Decreasing level of consciousness

Do this:

1. Stop physical activity.
2. **Repeat ______ puffs Quick Relief/Rescue medication.**
3. Call 911 and inform dispatch that the reason for call is asthma.

Physician Name:____ Signature: ____________________Date:____________
Address: ____ Phone: _______________________________________
(Physician stamp acceptable)

MIDDLE SCHOOL ONLY: *For self-carry orders:* School Nurse assessed student's knowledge of inhaler use on ___________.
Date

____ ____
School Nurse Signature Student Signature