Cleveland Heights-University Heights City Schools
Department of Student Services / School Health Services

School Year: ____________________

School Nurse Fax ________________

ASTHMA MEDICATION AUTHORIZATION AND ACTION PLAN

Student: ____ D.O.B. ______________ ID# ______________________
Address ____
School: ____________________ Grade: ________ Homeroom: ___________________ PE days______________

TO BE COMPLETED BY PHYSICIAN:

SYMPTOMS may include:	TRIGGERS may include:
☐ Tightness in chest ☐ Shortness of breath ☐ Coughing ☐ Wheezing ☐ Breathing hard and fast ☐ Nasal flaring	☐ Dust, molds, pollens, dust mites ☐ Food allergies ☐ Animals ☐ Temperature changes ☐ Strong odors, fumes, or perfumes ☐ Exercise ☐ Upper respiratory infections

List ALL current medications given at home
____
____
____

At the FIRST SIGNS of these symptoms, DO:

1. Have the student ESCORTED to the nurse's office if the symptoms occur at school.
2. Restrict physical activity and allow the student to rest.
3. Encourage the student to breathe slowly and relax.
4. Supervise administration of medication per physician's orders (see below).
5. If no improvement occurs in 15-20 minutes, contact parent/guardian.
6. If parent/guardian cannot be located and asthma is not improving, call 911.

To REDUCE incidents:

1. Eliminate irritants and avoid triggers in the environment.
2. Be alert to EARLY signs of respiratory distress.

Name of medication: ______________________________ **Form** of medication ☐ Inhaler ☐ Nebulizer

Dosage and Schedule of medication ____

START: ☐ When form received ☐ Other date: ______________________
STOP: ☐ End of school year ☐ Other date/duration: __________________

Restrictions and/or important side effects:____
Special storage requirements: ☐ none ☐ refrigerate ☐ Other: ________________________________

This student is both capable and responsible for self-administering this medication:
☐ NO ☐ YES, but supervised ☐ YES, Unsupervised This student may carry this medication: ☐ No ☐ Yes

Physician's name & Signature: ____________________________________ **Office #** ____________________

EMERGENCY PHONE NUMBERS:
Parent/Guardian name: __________________ Day #(s) ____________________
Other______________________________ Day #(s) ____________________

Permission is given for the nurse to contact the following health care provider in the event emergency contacts cannot be reached or for urgent health care information:

Parent signature ________________________ Date ________ School Nurse __________________Date__________

Revised 06/2022