Administration of Medication Consent Form & Asthma Action Plan

A. Parent/Guardian to Complete

Student Name: _____ Grade: _____ DOB: _____

Emergency Contact: _____ Emergency Contact phone number_____

I authorize the school nurse or designated staff to administer prescribed medication or treatment to my child at school as directed by the physician below. I will supply the medication in its original, pharmacy-labeled container. In accordance with the Nurse Practice Act, I also grant permission for the school nurse to communicate with the prescribing healthcare provider to ensure safe and effective care. This includes discussion of the prescription or treatment, its implementation at school, my child's response, and any relevant health information related to the medical indication for the medication.

Parent/Guardian Signature: _____ Print Name:_____ Date: _____

B. Physician/Medical Provider to Complete

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent Triggers: _____

Reaction	Symptoms	Action
Green Zone Peak flow: more than 80% of best Best Peak flow: _____	☐ Daily medications every day when feeling well *When asthma symptoms are controlled the way they should be, a quick-relief bronchodilator is not needed every day or even every week except to prevent exercise-induced symptoms or particular exposures.*	☐ Controller Medicine(s): once every 12 hours ☐ Rescue Medicine: _____ puffs every 4 -6 hours as needed ☐ Exercise Medicine: _____ puffs 15 minutes before activity as needed
Yellow Zone Peak flow: 50% to 79% of best	☐ Cough ☐ Mild Wheeze ☐ Shortness of breath ☐ Chest Tightness	☐ Rescue Medicine: _____ puffs every 4-6 hours as needed ☐ Other:_____
Red Zone *If breathing does not improve in response to rescue/quick-relief medication* Peak flow less than 50% of best	☐ Unable to take a deep breath, exhale fully, or speak more than short phrases; persistent cough that does not stop. ☐ Breathing is hard and fast, with shoulders lifting, ribs sticking out, or chest/neck muscles visibly pulling in; often easier only when sitting up or leaning forward. ☐ Fingernails, lips, or skin turn blue or gray; skin may become cold, clammy, or sweaty. ☐ Swelling of the throat, tongue, or limbs, along with trouble walking, talking, or sleeping due to shortness of breath	☐ Repeat Rescue Medicine: after 15- 30 minutes with _____ puffs. Do Not exceed repeat dose ☐ Call 911 if symptoms do not improve after 2nd treatment ☐ Call Parent ☐ Other: _____

Medications/Doses (Circle)

Control Medicine	Inhale	**Salmeterol**: Flovent HFA or Diskus	QVAR Redihaler	Alvesco	Arnu	Asmanex
		Other:				
Rescue/Quick Relief	Inhale	**Albuterol :** ProAir HFA	ProAir RespiClick	ProAir HFA	Ventolin HFA	Xopenex HFA
		Other:				
Nebulizer	Inhale	**Bronchodilator** Saline	**Corticosteroids**	Oral-as directed	Prednisone Prednisolone	Dexamethasone
		Other:			Other:	

Signature of Provider: _____ Print Name: _____ Date: _____

Address: _____ Phone: _____