

MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL AUTORIZACIÓN MÉDICA PARA MANEJO DEL ASMA EN LA ESCUELA

Student/Estudiante: _____ Birthdate/Fecha de nacimiento: _____ Grade/Grado: _____
Nurse/Enfermera(o): _____ Phone/Teléfono: _____ School/Escuela: _____ FAX: (509) 573-5050

**Parent Section
Sección de los padres**

I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. **By signing below I authorize that medical information pertaining to Asthma and use of medications listed below be exchanged with my student's school nurse in written and verbal forms. I further give permission for these orders to be faxed to the school.** *Yo pido que la enfermera o personal designado administre el siguiente medicamento recetado de acuerdo con las instrucciones del médico. Al firmar abajo doy autorización para que la información médica pertinente a Asma y al uso de los medicamentos anotados abajo sea comunicada a la enfermera de la escuela de mi estudiante en forma verbal y escrita. También doy permiso para que estas órdenes se envíen por fax a la escuela.*

I give permission for the nurse to initiate an Emergency Care Plan/504 Plan. ☐ Yes/Si ☐ No
Doy permiso para que la enfermera inicie un plan de cuidado de emergencia/plan 504.

I give permission for my child to self administer and carry this emergency medication. ☐ Yes/Si ☐ No
Doy permiso para que mi hijo se administre y cargue este medicamento de emergencia.

Signature/Firma_____
Date/Fecha_____
Phone #1_____
Números de teléfono Phone #2

Student's Symptoms/Síntomas del estudiante: _____

Student's Triggers/Causantes del asma del estudiante: _____

Home Controller Medications/Medicamentos de control en el hogar: _____

Student Riding Bus/El estudiante viaja en autobús ☐ Yes/Si ☐ No (911 will be called for any issues/Se llamará a 911 por cualquier problema)

☐ ***Student no longer needs inhaler at school/El estudiante ya no necesita un inhalador en la escuela _____
Signature/Firma Date/Fecha

*****LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW*****

*****EL PROVEEDOR DE SERVICIOS DE SALUD AUTORIZADO DEBE COMPLETAR LA SECCIÓN DE ABAJO*****

Asthma Severity ☐ Asthma ☐ Exercise Induced Asthma ☐ Reactive Airway

Any severe allergy? ☐ No ☐ Yes To What? _____ (Severe Allergy Form Needed)

Busing: 911 protocol to be used unless stated otherwise ☐ Other _____

QUICK RELIEF MEDICATION ORDER- Ordered With Spacer ☐ Yes ☐ No

☐ Albuterol (ProAir®, Ventolin®, Proventil®) ☐ Levalbuterol (Xopenex®) ☐ Symbicort ☐ Other _____

☐ *** Student no longer with need for inhaler at school

Medication side effects: restlessness, irritability, nervousness, rarely tremor, increased or irregular heart rate

YELLOW ZONE: Asthma symptoms (cough, wheeze, chest tightness, difficulty breathing)

☐ Give _____ puffs quick-relief inhaler ☐ If symptoms persist, repeat after 5 - 10 minutes

If no improvement after repeated dose follow Red Zone instructions below but give no more than _____ additional puffs of the inhaler

☐ May administer quick relief inhaler every _____ hours PRN

☐ Until symptoms resolve, restrict strenuous physical activity

RED ZONE: Severe symptoms (very short of breath, ribs visible during breathing, trouble walking or talking, color poor)

CALL 911 and School Nurse if available and do not leave student unattended

☐ Give 4 to _____ puffs quick-relief inhaler ☐ If symptoms persist repeat after 5 - 10 minutes

☐ Give Epi auto-injector 0.3 mg ☐ Give Epi Jr. auto-injector 0.15 mg ☐ NO Epinephrine

EXERCISE PRETREATMENT ☐ Yes ☐ No (If yes, check all that apply)

☐ Give 2 to _____ puffs quick-relief inhaler 15-30 minutes prior to ☐ PE ☐ recess ☐ sports

☐ Consistently **OR** ☐ PRN

☐ Pretreatment should not be given more often than every _____ hours

☐ May repeat _____ puffs of quick-relief inhaler **if symptoms occur** during activity

Medication order is valid for duration school year _____ (including summer school)

Recommend student self-administer and carry this emergency medication at school. ☐ Yes ☐ No

Licensed Health Care Provider Signature

Printed LHCP Name

Date

Health care provider phone

Health care provider FAX

Approval to self carry: Nurse

Principal