

Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for School Year _____ (including summer school) School: _GFS_ Grade: _____

Student Name: _____ Birth Date: _____ Peak Flow Personal Best: _____
Parent/Guardian's Name: _____ Home #: _____ Work #: _____ Cell #: _____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE				
CONTROLLER MEDICATIONS - TO BE USED DAILY AT HOME UNLESS OTHERWISE INDICATED				
Medication	Dose	Route	Frequency/Time	
☐ Breathing is good				
☐ No cough or wheeze				☐ School
☐ Can work, exercise, play				☐ School
☐ Other: _____				☐ School
☐ Peak flow greater than _____ (80% personal best)				☐ School

EXERCISE ZONE				
☐ Prior to exercise/sports/physical education (PE)	Medication (Rescue Medication)	Dose	Route	Frequency/Time
If using more than twice per week for exercise/ sports/PE notify healthcare provider and parent/guardian				

YELLOW ZONE				
☐ Cough or cold symptoms	RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS			
☐ Wheezing	Medication	Dose	Route	Frequency/Time
☐ Tight chest or shortness of breath				PRN
☐ Cough at night				PRN
☐ Other: _____				PRN
☐ Peak flow between _____ and _____ (50% - 79% personal best)	If symptoms do not improve in _____ minutes, notify healthcare provider and parent/guardian. If using more than twice per week, notify healthcare provider and parent/guardian.			

RED ZONE				
☐ Medication is not helping within 15-20 minutes	EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911			
☐ Breathing is hard and fast	Medication	Dose	Route	Frequency/Time
☐ Nasal flaring or intercostal retractions				
☐ Lips or fingernails blue				
☐ Trouble walking or talking				
☐ Other: _____				
☐ Peak flow greater than _____ (50% personal best)	CONTACT THE PARENT/GUARDIAN AFTER CALLING 911			

HEALTHCARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications: ☐ Yes ☐ No

Healthcare Provider Name: _____

Signature: _____

Office #: _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child: ☐ is ☐ is not authorized to self-carry his/her medication(s).

Signature: _____

Date: _____

RECEIVED IN HEALTH SUITE BY _____ DATE _____

REVIEWED BY SCHOOL NURSE

Name (Print): _____

Signature: _____

Date: _____

Authorized to self-carry medications: ☐ Yes ☐ No

Triggers

- ☐ Chalk dust
- ☐ Cigarette smoke
- ☐ Colds/Flu
- ☐ Dust/Dust mites
- ☐ Stuffed animals
- ☐ Carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests
- ☐ Pets
- ☐ Plants
- ☐ Flowers
- ☐ Cut grass
- ☐ Pollen
- ☐ Strong odors
- ☐ Perfume
- ☐ Cleaning products
- ☐ Sudden change in temperature
- ☐ Wood smoke
- ☐ Foods
- ☐ Other

This order is valid for one year from the date of prescriber's signature below.

School: Garrison Forest School

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed annually, for each medication, or when there is a change in dosage or time of administration of a medication.

- * Prescription medication must be in a container labeled by the pharmacist or prescriber.
- * Non-prescription medication must be in the original container with the label intact.
- * An adult must bring the medication to the school.
- * The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

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

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____

(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____

Signature

Date

School RN approval for self carry/self administration of emergency medication: _____

Signature

Date

Order reviewed by the school RN: _____

Signature

Date