

ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

		Today's Date:
Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	
KNOWN ASTHMA TRIGGERS: ☐ Exercise ☐ Pet Dander ☐ Mold ☐ Dust ☐ Pollen ☐ Colds ☐ Strong Odors ☐ Cold Air ☐ Pests ALLERGIES: _____		

Student's Asthma Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

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Give: Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) ☐ 10-15 minutes before exercise ☐ with spacer
(Circle One)

Nebulized Albuterol 2.5mg/Xopenex 0.63mg _____ Vial inhaled (by mouth) ☐ 10-15 minutes before exercise ☐ with nebulizer

OTHER: _____

(Follow CAUTION or DANGER ZONES of Asthma Action Plan)

Give (*Circle One*):

Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) ☐ every _____ hours ☐ with spacer

Nebulized Albuterol 2.5mg OR _____ Vial inhaled (by mouth) ☐ every ____ hours ☐ nebulizer
Nebulized Xopenex 0.63mg

OTHER: _____

*** If there is no improvement 20 minutes after taking the Rescue Medication: Notify provider**

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a

③ **Side Effect(s) to watch for:** Nervousness, Shaking, Palpitations, Headache _____ or ☐ None

④ Reaction to/or negative interaction with food or drugs: _____ or ☐ None

⑤ Self-Administration Authorization: ☐ This student is capable to safely and properly self-administer medication(s)
OR ☐ This student is not approved to self-administer medication(s)

⑥ Medication Start/End Dates (one year max)

Start: ____/____/____ End: ____/____/____

Health Care Provider's Signature: _____ **Date:** _____ **Phone #** _____

(ADD STAMP with Address and Phone

PARENT/GUARDIAN CONSENT :

- ☐ I authorize the student to possess and self-administer medication as described and directed above
- ☐ I authorize this medication to be administered by school personnel as described and directed above
- ☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- ☐ I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- ☐ I assume full responsibility for providing the school with the prescribed medication and spacer.
- ☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent Signature: _____ **Date:** _____

Name of Individual Receiving Written Authorization and Medication _____ Title/Position: _____
(PRINT & SIGN)

Nurse (if applicable): _____

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Note: This form is a sample in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v).



Asthma Action Plan & Medication Authorization

GO ZONE – You're Doing Well!

TAKE THESE MEDICINES EVERYDAY



If you have all of these:

- Breathing is good
- No cough or wheeze
- Sleep well at night
- Can work and play

CONTROLLER MEDICINE (Dose/Route)	HOW MUCH	HOW OFTEN	WHEN
1. _____	_____ Puffs Inhaled ☐ with spacer	_____	AM/PM
2. _____	_____	_____	AM/PM
3. _____	_____	_____	AM/PM
4. _____	_____	_____	AM/PM

CAUTION ZONE: – CONTINUE WITH EVERYDAY MEDICINE and ADD RESCUE MEDICINE SLOW DOWN !



If you have any of these:

- First signs of a cold
- Exposed to known Trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

DO THIS: Give (**Circle One**):

Albuterol MDI 90 or Xopenex MDI 45 _____ Puffs Inhaled ☐ every _____ hours ☐ with spacer
(by mouth)

Nebulized Albuterol 2.5mg _____ Vial inhaled ☐ every _____ hours ☐ nebulizer
OR Nebulized Xopenex 0.63mg (by mouth)

***CALL YOUR HEALTH PROVIDER IF:**

- There is no improvement 20 minutes after taking the Rescue Medication

Nurse: Call parent and/or provider if using Rescue medication more than 2 days/week for asthma symptoms or for control concerns

DANGER ZONE GET HELP!

TAKE THESE MEDICINES AND CALL YOUR PROVIDER NOW



If your Asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous

MEDICINE (Circle med)	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90 / Xopenex MDI 45	_____ Puffs Inhaled ☐ with spacer	NOW!
2. Nebulized Albuterol 2.5mg/Xopenex 0.63mg	_____ 1 vial inhaled	NOW!

***Call your Health Care Provider NOW, if they are not available,
Go to the emergency room or call 911 and bring this form with you.**

DO NOT WAIT!

Parent/Guardian: Make an appointment with your health care provider within 2 days of an ED visit, hospitalization, or anytime for ANY problem or question

Prescriber Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Nurse _____ Date _____