Shawano School District

O Hillcrest Primary School 715-524-2134 **(Fax) 715-524-1151**	O Shawano Middle School 715-526-2192 **(Fax) 715-201-4210** *** NEW ***
O Olga Brener Intermediate School 715-524-2131 **(Fax) 715-524-9899**	O Shawano High School 715-526-2175 **(Fax) 715-524-8414**

ASTHMA MEDICATION AUTHORIZATION and ASTHMA ACTION PLAN

Student's Name _____ Date of Birth _____ School year _____

Parent/Guardian _____ Phone _____

Cell phone/Alternate phone _____

Health Care Provider _____

DAILY MEDICATIONS (usually taken at home):

Location of medication while at school: (circle one)
Office / student's backpack / student carries on person / student's locker / other:

Health Care Provider: Please complete all items below, sign and date. THANK YOU!

SCHOOL INSTRUCTIONS FOR RESCUE INHALER

If student has

- ☐ Coughing
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Other _____

Medication _____
Dose _____
Frequency _____

INSTRUCTIONS FOR EXERCISE

- ☐ Use rescue inhaler prior to phy-ed
- ☐ Use rescue inhaler prior to recess

Always _____
Only when _____

☐ Student should not be outdoors when temperature is < _____

Physician authorization: ☐ Student may carry inhaler. ☐ Student may NOT carry inhaler.

Physician Name _____ **Phone** _____

Physician Signature _____ **Date** _____

***EMERGENCY* If the following is observed, CALL 911 IMMEDIATELY**

- Symptoms are getting worse following rescue inhaler administration.
- Student is struggling to breath- unable to speak or speaking in single words.
- Bluish lips, tongue, face.
- Wheezing began suddenly after eating, an insect bite, or taking a medication.
- Student becomes unconscious or faints.

Parent Authorization: ☐ Student may carry inhaler. ☐ Student may NOT carry inhaler.

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse.

Parent Signature _____ **Date** _____