

Asthma Action Plan & School Medication Authorization



Name: _____	DOB: _____	Date: _____
Important! Things that make your asthma worse (Triggers): ☐ smoke ☐ pets ☐ mold ☐ dust-mites ☐ pollen/trees ☐ colds/viruses ☐ exercise ☐ seasons: _____ other: _____		
Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent		

GO ZONE – You're Doing Well!

USE THESE MEDICINES EVERYDAY TO PREVENT SYMPTOMS

If you have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play



CONTROLLER MEDICINE (Dose/Route) HOW MUCH HOW OFTEN/WHEN

- | | | |
|---|--------------------------------------|--|
| 1. _____ | _____ Puffs Inhaled | AM/PM |
| | ☐ with spacer | |
| 2. _____ | _____ | AM/PM |
| 3. _____ | _____ | AM/PM |
| 4. Albuterol MDI 90 | _____ Puffs Inhaled with spacer | |
| ➤ Please order a VHC Spacer to use with any MDIs | | ☐ Every 4 hours as needed before exercise |

CAUTION ZONE – Slow Down!

CONTINUE WITH GO ZONE MEDICINE and ADD:

If you have any of these:

- First signs of a cold
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night



RESCUE MEDICINE HOW MUCH HOW OFTEN/WHEN

- | | | |
|---|---------------------------------|--|
| 1. Albuterol MDI 90 | _____ Puffs Inhaled with spacer | Every _____ hours |
| OR | | ☐ May Repeat x 1 in 20 minutes <i>if needed</i> |
| 2. Nebulized Albuterol 2.5mg | _____ Vial inhaled | Every _____ hours |
| | | ☐ May repeat x 1 in 20 minutes <i>if needed</i> |
| 3. _____ | _____ | _____ |
| ➤ If getting worse follow directions in DANGER ZONE and Call your Health Care Provider | | |
| ➤ If not improved in 2 days <u>or</u> any asthma questions/concerns - Call your Health Care Provider | | |

School Nurse: Call parent or provider if using PRN 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 HOW MUCH HOW OFTEN/WHEN

- | | | |
|--|---------------------------------|--|
| 1. Albuterol MDI 90 | _____ Puffs Inhaled with spacer | NOW! |
| OR | | ☐ Repeat x 1 in 20 minutes <i>if needed</i> |
| 2. Nebulized Albuterol 2.5mg | _____ 1 vial inhaled | NOW! |
| | | ☐ Repeat x 1 in 20 minutes <i>if needed</i> |
| ➤ Call your Health Care Provider now! If they are not available, go directly to the emergency room or call 911 and bring this form with you. Make an appointment after all E.R. visits. | | |

HEALTH CARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR Albuterol as stated in above plan, and in accordance with CT State Law and Regulations 10-212a * Not to exceed **6 puffs** within regular school hrs (6hrs), without notifying provider Office Stamp

Side effects: ☐ Not expected, or _____ Medication Allergies: ☐ NKDA, or _____

Self-Administration: ☐ This student is capable to safely and properly self-administer this medication **OR**
☐ This student is not approved to self-administer this medication

Signature: _____ Date: _____ Duration: One school year /365 days

Parent/Guardian Consent: REQUIRED

☐ I authorize the student to **possess** and **self-administer** medication **OR** ☐ I authorize this medication to be **administered by school personnel**

➤ I authorize exchange of information between the prescribing health care provider and school nurse to ensure the safe administration of this medication plan

Signature: _____ Date: _____ *** Bring asthma meds and spacer to all visits**

Nurse Signature: _____ Date: _____ **Acknowledges review of Medication Plan**