MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

_____School District Fax _____

Student Name: _____ Birth date: _____ Grade: _____

Parent Section

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the
healthcare provider instructions. I understand that this information will be shared with school staff on a "need to know" basis.

I give permission for my child to carry this medication. ☐Yes ☐No

I give permission for my child to self-administer this medication. ☐Yes ☐No

I give permission for the nurse to initiate a 504 plan. (see Parent and Student Rights Attached) ☐Yes ☐No

Signature _____ Date _____ Phone _____

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW

Asthma Severity: ☐Intermittent ☐Persistent ☐Mild ☐Moderate ☐Severe

Usual Symptoms _____

Student's Asthma Triggers _____

Home Controller Medications _____

Any severe Allergy No☐ Yes☐ To What? _____

_____

Quick Relief Medication Orders Spacer ☐Yes ☐ No

☐Albuterol (ProAir, Ventolin, Proventil) ☐Levalbuterol (Xopenex)

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 not 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
EXERCISE PRETREATMENT☐ Yes ☐ No (If yes, check all that apply) Give 2 to ____puffs quick- relief inhaler 15-30 prior to ☐ PE ☐ Recess ☐ Sports		

☐Consistently or PRN
☐Pretreatment should not be given more often than every _____hour.

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

Medication order is valid for duration of _____ school year (which includes summer school)

This student may carry this emergency medication at school. ☐ Yes ☐ No
This student is trained and capable of self-administering this emergency medication. ☐ Yes ☐ No

Licensed Health Care Provider Signature | Printed LHCP Name

Date | Health care provider phone | Health care provider FAX