Asthma Action Plan & School Medication Authorization

Name:	Birth Date:	Date:
Parent/Guardian Phone #'s:	Provider: Phone#: Fax#:	

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 – You're Doing Well! USE THESE **MEDICINES EVERYDAY** TO PREVENT SYMPTOMS

You have *all* of these:

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

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
1.	_____ puffs ☐ ***with Spacer***	AM / PM
2.	_____ squirt(s) each nostril	AM / PM
3.		AM / PM
4.		AM / PM

☺ **Always use a Spacer with your Inhaler**

CAUTION – Slow Down! Continue with Green Zone Medicine and ADD:

You have *any* of these:

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

MEDICINE *(Circle one)*	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol / Xopenex	2 puffs &/or 1 vial (____mg) ☐ ***with Spacer***	Every _____ Hours ☐ Before Exercise ***as needed***
2.		AM / PM

CALL our Office if: You need these medicines SOONER than EVERY 4 HOURS or EVERY 4 HOURS for MORE than 2 days or for **any** questions

HEALTHCARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR Albuterol /Xopenex(Levalbuterol) **as stated** *in accordance with CT State Law and Regulations 10-212a* Side effects:_____ or ☐Not relevant Medication Allergies:_____ or ☐ NKDA

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

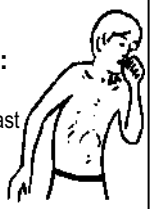
Signature:_____ **Provider Printed Name:**_____ **Date:**_____ **for School Year:**_____

School Nurse: Call if using PRN medication more than 2 times/week for asthma symptoms or for control concerns

DANGER – Get Help! TAKE THESE MEDICINES AND CALL YOUR PROVIDER NOW

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
Albuterol / Xopenex	4 puffs	NOW! ☐Repeat in _____minutes if needed

Call your doctor now! Do not be afraid of causing a fuss. It's important! If you cannot contact your doctor, go directly to the emergency room or call 911 and bring this form with you. DO NOT WAIT.

✓ Make an appointment with your primary care provider within **two days** of an **ED visit, hospitalization**, or anytime for **ANY** problem or question with asthma

Parent/Guardian Consent: REQUIRED

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

I also authorize communication between the prescribing health care provider and school nurse necessary for asthma management and administration of this medication

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

Follow-Up Visit:_____ **School Nurse Fax #**_____