MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

Click here to enter text. School District Fax Click here to enter text.

Student Name: Click or tap here to enter text. Birth date: Click or tap to enter a date. Grade: Click or tap here to enter text.

Parent Section *Seccion de Padres*

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.
Yo pido que la enfermera o personal designado, le administer el medicamento recetado de acuerdo con las instrucciones del medico. You entiendo que cualquier informacion de este formulario sera comunicada al personal escolar que mecesite estar informado.

I give permission for my child to carry this medication. *Doy permiso para que mi hijo/hija pueda cargar su medicamento.*	☐Yes\Si ☐No
I give permission for my child to self-administer this medication. *Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.*	☐Yes\Si ☐No
I give permission for the nurse to initiate a 504 plan. (see Parent and Student Rights Attached) *Doy permiso para la enfermera de iniciar un plan de cuidado de emergencia/ plan 504.*	☐Yes\Si ☐No

Signature/ Firma Date/ Fecha Phone / telefono

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW

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

Usual Symptoms Click or tap here to enter text.

Student's Asthma Triggers Click or tap here to enter text.

Home Controller Medications Click or tap here to enter text.

Any severe Allergy No☐ Yes☐ To What? Click or tap here to enter text.

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 Click or tap here to enter text. 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 Click or tap here to enter text. **Additional puffs of the inhaler.**

☐May administer quick relief inhaler every Click or tap here to enter text. 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 ___Click or tap here to enter text.__puffs quick- relief inhaler 15-30 prior to ☐ PE ☐ Recess ☐ Sports

☐Consistently or PRN

☐Pretreatment should not be given more often than every Click or tap here to enter text. hour.

May repeat Click or tap here to enter text. puffs of quick-relief inhaler if symptoms occur during activity

Medication order is valid for duration of current 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

	Click or tap here to enter text.
Licensed Health Care Provider Signature	Printed LHCP Name

Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
Date	Health care provider phone	Health care provider FAX