MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

Registered Nurse Contact Numbers: 509-488-3351 EXT 2029 and 2015

Student:_____Birth Date:_____ Grade:_____

Parent Section *Seccion Padres*

I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. **I give my permission for the following medication information to be shared with school staff on a "need to know" basis.**

Yo pido que la enfermera o personal designado le adminstre el medicamento recetado de acuerdo con las instrucciones del medico. ***Doy permiso que la siguiente información sea compartida con el personal escolar que necesite estar informado.***

I give permission for the nurse to initiate an **Emergency Care Plan**/504 Plan. ☐ Yes/*si* ☐ No
Yo doy permiso para la enfermera de inciciar un plan de cuidado de emergencia/plan 504

I give permission for my child to carry this emergency medication. ☐ Yes/*si* ☐ No
Doy permiso para que mi hijo/hija pueda cargar su medicamento de emergencia

I give permission for my child to self-administer this emergency medication. ☐ Yes/*si* ☐ No
Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento de emergencia

_____

Signature/Firma ***Date/Fecha*** ***Phone #1*** ***Numeros de telefonos*** ***Phone #2***

_ _ _ _ _ _ _ _ _ LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW _ _ _ _ _ _ _ _ _

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

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 within 10 minutes after repeated dose, follow Red Zone instructions below but give no 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

☐ Give Epi auto-injector 0.3 mg ☐ Give Epi Jr. auto-injector 0.15 mg ☐ NO Epinephrine

EXERCISE PRETREATMENT ☐ Yes ☐ No (If yes, check all that apply)

☐ Give 2 to _____ puffs quick-relief inhaler 15-30 minutes prior to ☐ PE ☐ recess ☐ sports

☐ Consistently **OR** ☐ PRN

☐ Pretreatment should not be given more often than every _____ hours

☐ May repeat _____ 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

_____ _____

Licensed Health Care Provider Signature *Printed LHCP Name*

_____ _____ _____

Date *Health care provider phone* *Health care provider FAX*