

MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

Thorp School District Fax# 509-964-2313

Student: _____ Birth Date: _____ Grade: _____

Parent Section Sección 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. <i>Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del medico. Yo entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.</i>	
	I give permission for my child to carry this medication. <i>Doy permiso para que mi hijo/hija pueda cargar su medicamento.</i>	<input type="checkbox"/> Yes/sí <input type="checkbox"/> No
	I give permission for my child to self-administer this medication. <i>Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.</i>	<input type="checkbox"/> Yes/sí <input type="checkbox"/> No
	I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) <i>Doy permiso para la enfermera de iniciar un plan de cuidado de emergencia/plan 504.</i>	<input type="checkbox"/> Yes/sí <input type="checkbox"/> No
_____ Signature/Firma		_____ Date/Fecha
_____ Phone #1		_____ Números de teléfonos
_____ Phone #2		

----- **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 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

May, 2014