

ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

PARENT/GUARDIAN: Complete and Sign this portion and the medication authorization below		Today's Date:
Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	
1 KNOWN ASTHMA TRIGGERS: <input type="checkbox"/> Exercise <input type="checkbox"/> Pet Dander <input type="checkbox"/> Mold <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Colds <input type="checkbox"/> Strong Odors <input type="checkbox"/> Cold Air <input type="checkbox"/> Pests		
2 ALLERGIES: _____		

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS BELOW, SIGN AND DATE. THANK YOU!
Asthma Medication(S) To Be Given:

Student's Asthma Severity Classification: Intermittent Mild Persistent Moderate Persistent Severe Persistent

A Exercise Pre-treatment: Not Required Before Recess Before PE/Sports

Give: Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) 10-15 minutes before exercise with spacer
 (Circle One)
 Nebulized Albuterol 2.5mg/Xopenex 0.63mg _____ Vial inhaled (by mouth) 10-15 minutes before exercise with nebulizer

OTHER: _____

B RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING
 (Follow CAUTION or DANGER ZONES of Asthma Action Plan)

Give (Circle One):
Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) every ___ hours with spacer

Nebulized Albuterol 2.5mg OR _____ Vial inhaled (by mouth) every ___ hours nebulizer
Nebulized Xopenex 0.63mg

OTHER: _____

* If there is no improvement 20 minutes after taking the Rescue Medication: **Notify provider**

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a

3 Side Effect(s) to watch for: Nervousness, Shaking, Palpitations, Headache _____ or None

4 Reaction to/or negative interaction with food or drugs: _____ or None

5 Self-Administration Authorization: This student is capable to safely and properly self-administer medication(s)
OR This student is not approved to self-administer medication(s)

6 Medication Start/End Dates (one year max)
 Start: ___/___/___ End: ___/___/___

Health Care Provider's Signature: _____ Date: _____ Phone # _____
 (ADD STAMP with Address and Phone)

PARENT/GUARDIAN CONSENT :

I authorize the student to possess and self-administer medication as described and directed above

I authorize this medication to be administered by school personnel as described and directed above

I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.

I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

I assume full responsibility for providing the school with the prescribed medication and spacer.

I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent Signature: _____ Date: _____

Name of Individual Receiving Written Authorization and Medication _____ Title/Position: _____
 (PRINT & SIGN)

Asthma Action Plan & Medication Authorization

GO ZONE – You're Doing Well! TAKE THESE MEDICINES EVERYDAY



If you have all of these:

- Breathing is good
- No cough or wheeze
- Sleep well at night
- Can work and play

CONTROLLER MEDICINE (Dose/Route)	HOW MUCH	HOW OFTEN	WHEN
1. _____	_____ Puffs Inhaled	_____	AM/PM
2. _____	_____ <input type="checkbox"/> with spacer	_____	AM/PM
3. _____	_____	_____	AM/PM
4. _____	_____	_____	AM/PM

CAUTION ZONE: – CONTINUE WITH EVERYDAY MEDICINE and ADD RESCUE MEDICINE SLOW DOWN !



If you have any of these:

- First signs of a cold
- Exposed to known Trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

DO THIS: Give (Circle One):

Albuterol MDI 90 or Xopenex MDI 45 _____ Puffs Inhaled every ____ hours with spacer (by mouth)

Nebulized Albuterol 2.5mg _____ Vial inhaled every ____ hours nebulizer
OR Nebulized Xopenex 0.63mg (by mouth)

***CALL YOUR HEALTH PROVIDER IF:**

➤ **There is no improvement 20 minutes after taking the Rescue Medication**

Nurse: Call parent and/or provider if using Rescue medication more than 2 days/week for asthma symptoms or for control concerns

DANGER ZONE – GET HELP! TAKE THESE MEDICINES AND CALL YOUR PROVIDER NOW



If 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 (<u>Circle med</u>)	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90 / Xopenex MDI 45	_____ Puffs Inhaled	NOW!
	<input type="checkbox"/> with spacer	
2. Nebulized Albuterol 2.5mg/Xopenex 0.63mg	_____ 1 vial inhaled	NOW!

***Call your Health Care Provider NOW, if they are not available, Go to the emergency room or call 911 and bring this form with you.**

DO NOT WAIT!

Parent/Guardian: Make an appointment with your health care provider within 2 days of an ED visit, hospitalization, or anytime for ANY problem or question

Prescriber Signature Date

Parent/Guardian Signature Date

Nurse Date