

SAMPLE MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

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

Student: _____ Birth Date: _____ Grade: _____

Parent Section <i>Sección de Padres</i>	<p>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></p> <p>I give permission for my child to carry this medication. <input type="checkbox"/> Yes/sí <input type="checkbox"/> No <i>Doy permiso para que mi hijo/hija pueda cargar su medicamento.</i></p> <p>I give permission for my child to self-administer this medication. <input type="checkbox"/> Yes/sí <input type="checkbox"/> No <i>Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.</i></p> <p>I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) <input type="checkbox"/> Yes/sí <input type="checkbox"/> No <i>Doy permiso para la enfermera de iniciar un plan de cuidado de emergencia/plan 504.</i></p>
<p>_____ <i>Signature/Firma</i> <i>Date/Fecha</i> <i>Phone #1</i> <i>Números de teléfonos</i> <i>Phone #2</i></p>	

----- 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