MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

Zillah School District. **Faxes:** K-3 & Nurse: 829-6470; 4-6: 829-3575; 7-8: 829-0754; 9-12: 829-5285; District: 829-5360

Student:________________________________ Birth Date:____________________ Grade:________

Parent Section *Seccion des 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 iniciar 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*