# MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

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

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.

*Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del medic entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.*

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

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

I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) ☐ Yes/*sí* ☐ No
*Doy permiso para la enfermera de iniciar un plan de cuidado de emergencia/plan 504.*

____________________________ ____________ ________________ __________________
*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 and on the bus. ☐ 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*