HIGHLAND SCHOOL DISTRICT 203

MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

SCHOOL: _____ **YEAR:** _____

STUDENT: _____ **DOB:** _____ **AGE:** _____
GRADE: _____ **PARENT/GUARDIAN** (PRINT): _____

PARENT/GUARDIAN SECTION SECCIÓN DE PADRE/GUARDIAN

I request the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare instructions. I give permission for the following medication information to be shared with school staff on a "need to know" basis.

Solicito a la enfermera de la escuela, o al miembro del personal designado, que administre el medicamento prescrito a continuación, de acuerdo con las instrucciones de atención médica. Doy permiso para que la siguiente información sobre medicamentos se comparta con el personal de la escuela según la "necesidad de saber".

FOR INHALERS ONLY (PARA INHALADORES SOLAMENTE):

I give permission for my child to carry this emergency medication. _____ Yes/ Si _____ No
Doy permiso para que mi hijo/hija lleve este medicamento de emergencia.

I give permission for my child to self-administer this medication. _____ Yes/ Si _____ No
Doy permiso para que mi hijo/hija se auto administré este medicamento.

_____	_____	_____	_____/_____
Parent/Guardian Signature Firma de Padre/Guardian	Date Fecha	Home Phone Teléfono de Casa	Emergency phone Teléfono de Emergencia

- - - - - - - - - - - LICENSED HEALTHCARE PROVIDER TO COMPLETE SECTIONS 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®) ☐ Other: _____

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 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 of quick-relief inhaler ☐ If symptoms persist repeat after 5-10 minutes

EXERCISE PRETREATMENT ☐ No ☐ Yes (If yes, check all that apply)

☐ Give 2 to _____ puffs of 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 only valid for current school year (which may include summer school) Year: _____
☐ Medication order valid only for specified date range: _____/_____/_____ to _____/_____/_____
This student may carry their emergency medication at school. ☐ Yes ☐ No
This student is trained and capable of self-administering this emergency medication. ☐ Yes ☐ No

HCP signature: _____ Date: _____

HCP Printed name: _____ Phone: _____

ONE FORM PER MEDICATION