MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL
AUTORIZACIÓN MÉDICA PARA MANEJO DEL ASMA EN LA ESCUELA

Student/Estudiante: _____ Birthdate/Fecha de nacimiento: _____ Grade/Grado: ___

Nurse/Enfermera(o):_____ Phone/Teléfono:_____ School/Escuela: _____ FAX: _____

PARENT SECTION / SECCIÓN DE LOS PADRES

I request the school nurse or designated staff member administer the following medication in accordance with healthcare provider instructions. By signing below, I authorize that medical information pertaining to Asthma and use of medications listed below be exchanged with my student's school nurse in written and verbal forms. I further give permission for these orders to be faxed to the school*. Yo pido que la enfermera o personal designado administre el siguiente medicamento recetado de acuerdo con las instrucciones del médico. Al firmar abajo doy autorización para que la información médica pertinente a Asma y al uso de los medicamentos anotados abajo sea comunicada a la enfermera de la escuela de mi estudiante en forma verbal y escrita. También doy permiso para que estas órdenes se envíen por fax a la escuela.*

I give permission for the nurse to initiate an Emergency Care Plan/504 plan ☐ Yes/Si ☐ No
Doy permiso para que la enfermera inicie un plan de cuidado de emergencia/plan 504

I give permission for my child to self administer and carry this medication. ☐ Yes/Si ☐ No
Doy permiso para que mi hijo se administre y cargue este medicamento de emergencia.

_____ _____ _____ _____
Signature/Firma | Date/Fecha | Phone #1 | Phone #2

Student's Symptoms/*Síntomas del estudiante*: _____

Student's Triggers/*Causantes del asma del estudiante*: _____

Home Controller Medications/*Medicamentos de control en el hogar*:_____

Student Riding Bus/*El estudiante viaja en autobús* ☐ **Yes/*Si*** ☐ **No (911 will be called for any issues/Se llamará a 911 por cualquier problema)**

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW
EL PROVEEDOR DE SERVICIOS DE SALUD AUTORIZADO DEBE COMPLETAR LA SECCIÓN DE ABAJO

Diagnosis: ☐Asthma Active ☐History of Asthma ☐Reactive Airway Disease ☐Other:_____

Any severe allergies? ☐ No ☐ Yes, To What?_____(Severe Allergy Form Needed)

Busing: 911 protocol to be used unless stated otherwise ☐Other_____

QUICK RELIEF MEDICATION ORDER- Ordered With Spacer ☐Yes ☐No

☐Albuterol (ProAir®, Ventolin®, Proventil®) ☐ Levalbuterol (Xopenex®) ☐ Symbicort ☐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 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 school year_____ (including summer school)

Recommend student self-administer and carry this emergency medication at school. ☐ Yes ☐ No

_____ _____
Licensed Health Care Provider Signature | *Printed LHCP Name*

_____ _____ _____
Date | *Health care provider phone* | *Health care provider FAX*

Updated 03/21/24