

ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

PARENT/GUARDIAN: Complete and Sign this portion and the medication authorization below		Today's Date:
Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	
<input type="checkbox"/> KNOWN ASTHMA TRIGGERS: <input type="checkbox"/> Exercise <input type="checkbox"/> Pet Dander <input type="checkbox"/> Mold <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Colds <input type="checkbox"/> Strong Odors <input type="checkbox"/> Cold Air <input type="checkbox"/> Pests		
<input type="checkbox"/> ALLERGIES: _____		

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS BELOW, SIGN AND DATE. THANK YOU!
Asthma Medication(S) To Be Given:

Student's Asthma Severity Classification: Intermittent Mild Persistent Moderate Persistent Severe Persistent

(A) Exercise Pre-treatment: Not Required Before Recess Before PE/Sports

Give: Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs inhaled (by mouth) 10-15 minutes before exercise with spacer
 (Circle One)
 Nebulized Albuterol 2.5mg/Xopenex 0.63mg _____ Vial inhaled (by mouth) 10-15 minutes before exercise with nebulizer

OTHER: _____

(B) RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING
(Follow CAUTION or DANGER ZONES of Asthma Action Plan)

Give (Circle One):
 Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) every _____ hours with spacer

Nebulized Albuterol 2.5mg **OR** _____ Vial inhaled (by mouth) every _____ hours nebulizer
 Nebulized Xopenex 0.63mg

OTHER: _____

* If there is no improvement 20 minutes after taking the Rescue Medication: **Notify provider**

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a

Side Effect(s) to watch for: Nervousness, Shaking, Palpitations, Headache _____ or None

Reaction to/or negative interaction with food or drugs: _____ or None

Self-Administration Authorization: This student is capable to safely and properly self-administer medication(s)
OR This student is not approved to self-administer medication(s)

(C) Medication Start/End Dates (one year max)
 Start: ____/____/____ End: ____/____/____

Health Care Provider's Signature: _____ Date: _____ Phone # _____
 (ADD STAMP with Address and Phone)

PARENT/GUARDIAN CONSENT :

- I authorize the student to possess and self-administer medication as described and directed above
- I authorize this medication to be administered by school personnel as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I assume full responsibility for providing the school with the prescribed medication and spacer.
- I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent Signature: _____ Date: _____

Name of Individual Receiving Written Authorization and Medication _____ Title/Position: _____
 (PRINT & SIGN)



