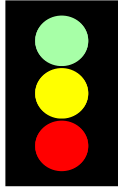
Asthma Action Plan & School Medication Authorization



Name:	DOB:	Date:

Important! Things that make your asthma worse (Triggers): □ smoke □ pets □mold □dust-mites □pollen/trees □colds/viruses □exercise □seasons: other:

Severity Classification: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

GO ZONE – You're Doing Well! USE THESE MEDICINES EVERYDAY TO PREVENT SYMPTOMS

If you have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

CONTROLLER MEDICINE (Dose/Route)	HOW MUCH	HOW OFTEN/WHEN
1. ______________________	________ Puffs Inhaled □ with spacer	AM/PM
2. ______________________	________	AM/PM
3. ______________________	________	AM/PM
4. Albuterol MDI 90	________ Puffs Inhaled with spacer	☐ Every 4 hours as needed before exercise

➢ Please order a VHC Spacer to use with any MDIs

CAUTION ZONE – Slow Down! CONTINUE WITH GO ZONE MEDICINE and ADD:

If you have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

RESCUE MEDICINE	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90	________ Puffs Inhaled with spacer	Every _____ hours ☐May Repeat x 1 in 20 minutes ***if needed***
OR		
2. Nebulized Albuterol 2.5mg	________ Vial inhaled	Every _____ hours ☐ May repeat x 1 in 20 minutes ***if needed***
3. ______________	________	______________

➢**If getting worse follow directions in DANGER ZONE and Call your Health Care Provider**

➢**If not improved in 2 days or any asthma questions/concerns - Call your Health Care Provider**

School Nurse: Call parent or provider if using PRN medication more than 2 days/week for asthma symptoms or for control concerns

DANGER ZONE – Get Help! TAKE THESE MEDICINES AND CALL YOUR PROVIDER NOW

If your Asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90	________ Puffs Inhaled with spacer	**NOW!** ☐ Repeat x 1 in 20 minutes ***if needed***
OR		
2 .Nebulized Albuterol 2.5mg	________ 1 vial inhaled	**NOW!** ☐ Repeat x 1 in 20 minutes ***if needed***

➢ **Call your Health Care Provider now! If they are not available, go directly to the emergency room or call 911 and bring this form with you. Make an appointment after all E.R. visits.**

HEALTH CARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED **FOR Albuterol** as stated in above plan, and in accordance with Ohio Revised Code (ORC) 3313.713 and Orange School District Use of Medication Policy 5330. * Not to exceed **6 puffs** within regular school hrs (6hrs), without notifying provider

Side effects: ☐Not expected, or ______________________ Medication Allergies:☐ NKDA, or ________________

Self–Administration: ☐This student **is** capable to safely and properly self-administer this medication **OR**
☐This student **is not** approved to self-administer this medication

Signature: Date: Duration: One school year /365 days

Parent/Guardian Consent: REQUIRED

☐ I authorize the student to **possess** and **self-administer** medication **OR** ☐ I authorize this medication to be **administered by school personnel**

➢ I authorize exchange of information between the prescribing health care provider and school nurse to ensure the safe administration of this medication plan

Signature: Date: *** Bring asthma meds and spacer to all visits**

Nurse Signature Date: Acknowledges review of Medication Plan