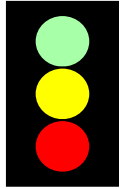



# Asthma Action Plan & School Medication Authorization




Name: _____	DOB: _____	Date: _____
<b>Important! Things that make your asthma worse (Triggers):</b> <input type="checkbox"/> smoke <input type="checkbox"/> pets <input type="checkbox"/> mold <input type="checkbox"/> dust-mites <input type="checkbox"/> pollen/trees <input type="checkbox"/> colds/viruses <input type="checkbox"/> exercise <input type="checkbox"/> seasons: _____ other: _____		
<b>Severity Classification:</b> <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> 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 <input type="checkbox"/> with spacer	AM/PM
2. _____	_____	AM/PM
3. _____	_____	AM/PM
4. Albuterol MDI 90	_____ Puffs Inhaled with spacer	
➤ <b>Please order a VHC Spacer to use with any MDIs</b>		<input type="checkbox"/> Every 4 hours as needed before exercise


**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
<b>OR</b>		<input type="checkbox"/> May Repeat x 1 in 20 minutes <i>if needed</i>
2. Nebulized Albuterol 2.5mg	_____ Vial inhaled	Every _____ hours
		<input type="checkbox"/> May repeat x 1 in 20 minutes <i>if needed</i>
3. _____		
➤ <b>If getting worse follow directions in DANGER ZONE and Call your Health Care Provider</b>		
➤ <b>If not improved in 2 days or any asthma questions/concerns - Call your Health Care Provider</b>		

**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	<b>NOW!</b>
<b>OR</b>		<input type="checkbox"/> Repeat x 1 in 20 minutes <i>if needed</i>
2. Nebulized Albuterol 2.5mg	_____ 1 vial inhaled	<b>NOW!</b>
		<input type="checkbox"/> Repeat x 1 in 20 minutes <i>if needed</i>
➤ <b>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.</b>		

**HEALTH CARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR Albuterol** as stated in above plan, and in accordance with CT State Law and Regulations 10-212a \* Not to exceed **6 puffs** within regular school hrs (6hrs), without notifying provider Office Stamp

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**