



# MEDICAL AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL

WEST VALLEY School District Fax# [Click here to enter text.](#)

Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

<b>Parent Section</b> <i>Sección de Padres</i>	I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions. I understand that this information will be shared with school staff on a "need to know" basis. <i>Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del medico. Yo entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.</i>	
	I give permission for my child to carry this medication. <i>Doy permiso para que mi hijo/hija pueda cargar su medicamento.</i>	<input type="checkbox"/> Yes/sí <input type="checkbox"/> No
	I give permission for my child to self-administer this medication. <i>Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.</i>	<input type="checkbox"/> Yes/sí <input type="checkbox"/> No
	I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) <i>Doy permiso para la enfermera de iniciar un plan de cuidado de emergencia/plan 504.</i>	<input type="checkbox"/> Yes/sí <input type="checkbox"/> No
_____ <i>Signature/Firma</i>		_____ <i>Date/Fecha</i>
_____ <i>Phone #1</i>		_____ <i>Números de teléfonos</i>
_____ <i>Phone #2</i>		

## LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION 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®)

*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 of current school year (which includes summer school)

This student may carry this emergency medication at school and on the bus.  Yes  No

This student is trained and capable of self-administering this emergency medication.  Yes  No

\_\_\_\_\_  
*Licensed Health Care Provider Signature*

\_\_\_\_\_  
*Printed LHCP Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Health care provider phone*

\_\_\_\_\_  
*Health care provider FAX*