MEDICAL AUTHORIZATION FOR ASTHMA Management AT SCHOOL

 Oak Park School District Fax# 248-336-7638- Attn: District Nurse

Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_

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|  **Parent Section** | 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 give permission for my child to carry this medication. [ ]  Yes [ ]  NoI give permission for my child to self-administer this medication. [ ]  Yes [ ]  NoI give permission for the social worker/nurse to initiate a 504 plan. [ ]  Yes [ ]  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature Date Primary Phone Alternate Phone* |

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Asthma Severity [ ]  Intermittent **[ ]** Persistent**: [ ]** Mild **[ ]** Moderate **[ ]** Severe

Usual Symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Asthma Triggers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Controller Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any severe allergy?** **[ ]**  No **[ ]** Yes To What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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, shortness of breath, chest tightness, difficulty breathing)***  [ ]  Give \_\_\_\_\_\_\_ puffs quick-relief inhaler **OR** 1 nebulizer treatment of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  If not breathing better after 2 treatments, 20 minutes apart, GO TO RED ZONE. ***If no improvement after repeated dose follow Red Zone instructions below***  [ ]  May administer quick relief inhaler every \_\_\_\_\_\_\_\_ hours PRN [ ]  Until symptoms resolve, restrict strenuous physical activity**CALL the PARENT**: If at any time, quick-relief medicine does not last for 4 hours, OR if quick-release medicine is needed more than 2 times a week. Parent should notify physician for evaluation. |
| **RED ZONE: Severe symptoms *(very short of breath,* *ribs visible during breathing, trouble walking or talking, color poor)*** [ ]  Give \_\_\_\_\_\_\_ puffs quick-relief inhaler **OR** 1 nebulizer treatment of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**If the student is not better right away, CALL 911 and do not leave student unattended. Contact parent.** **School Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **EXERCISE PRETREATMENT** [ ]  Yes [ ]  No (If yes, check all that apply)   [ ]  Give \_\_\_\_\_\_\_\_ puffs quick-relief inhaler 15-30 minutes prior to [ ]  PE [ ]  Recess [ ]  Sports  [ ]  Consistently **OR** [ ]  Only as needed [ ]  Pretreatment should not be given more often than every \_\_\_\_\_\_\_\_ hours [ ]  May repeat \_\_\_\_\_\_\_\_ puffs of quick-relief inhaler **if symptoms occur** during activity, not to exceed \_\_\_\_\_\_ puffs in \_\_\_\_\_\_ hours. |

 **Medication order is valid for duration of current school year (which includes summer school)**

This student may carry this emergency medication at school. [ ]  Yes [ ]  No

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

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*Physician’s Signature Printed Physician’s Name*

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*Date Phone FAX*