ASTHMA MEDICATION AUTHORIZATION and ASTHMA ACTION PLAN

Student's Name ______________________________ Date of Birth __________ School year ________
Parent/Guardian ______________________________ Phone ______________________________
Cell phone/Alternate phone ____
Health Care Provider____

DAILY MEDICATIONS (usually taken at home):
Location of medication while at school: (circle one) Office / student's backpack / student carries on person / student's locker / other:

Health Care Provider: Please complete all items below, sign and date. THANK YOU!	
SCHOOL INSTRUCTIONS FOR RESCUE INHALER If student has ☐ Coughing ☐ Wheezing ☐ Shortness of breath ☐ Chest tightness ☐ Other __________ Medication ______________________________ Dose ______________________________ Frequency ______________________________	**INSTRUCTIONS FOR EXERCISE** ☐ Use rescue inhaler prior to phy-ed ☐ Use rescue inhaler prior to recess Always ______________________ Only when ______________________ ☐ Student should not be outdoors when temperature is < _____
Physician authorization: ☐ Student may carry inhaler. ☐ Student may NOT carry inhaler.	
Physician Name ______________________________ **Phone** ____________________ **Physician Signature** ______________________________ **Date** ____________________	

EMERGENCY **If the following is observed, CALL 911 IMMEDIATELY**

- Symptoms are getting worse following rescue inhaler administration.
- Student is struggling to breath- unable to speak or speaking in single words.
- Bluish lips, tongue, face.
- Wheezing began suddenly after eating, an insect bite, or taking a medication.
- Student becomes unconscious or faints.

Parent Authorization: ☐ Student may carry inhaler. ☐ Student may NOT carry inhaler.
Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse.

Parent Signature ____ **Date** ____________________