CHESS Christian School

ASTHMA ACTION PLAN/INHALED ASTHMA MEDICATION AUTHORIZATION

(In accordance with ORC 3313.713/3313.716)

Student Information *(Please print)*

Name:	Birth Date:	Place Student Picture Here
Address:	Phone:	
School:	Grade/Teacher:	

Parent/Guardian Authorization (All parents to complete)

1. As the Parent / Guardian of this student: I authorize an employee of the school board to administer the prescribed medication at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
2. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
3. I also authorize CHESS Christian School's registered nurse to talk with the prescriber or pharmacist to clarify medication order.
4. I give permission for this information to be sent to the school via facsimile.
5. Medication form must be received by the principal, his/her designee, and/or CHESS Christian School's registered nurse.
6. I understand that the medication must be in the original container and be properly labeled with the students name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of the expiration.

Please contact parent/guardian if_____

Parent/Guardian Name:	Phone #1:	Phone #2:
Parent/Guardian Signature:	Date:	

Parent/Guardian Self-Carry Authorization (Only complete if the student is going to self-carry)

1. As the parent/Guardian of this student: **I authorize** my child to possess and self-administer an inhaled asthma medication, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
2. **Please consider providing a backup inhaler for the school clinic.**
3. As the parent/Guardian of this student: I understand that if this medication is self-administered, and the student does not get expected relief, the student must notify a staff member who will facilitate notifying the registered nurse.

Parent/Guardian Name:	Phone #1:	Phone #2:
Parent/Guardian Signature:	Date:	

Special considerations and precautions for school activities, sports, field trips:

1. Staff member in charge of the school sponsored event will be trained by the *school's registered nurse* in the administration of multi dose inhaler (MDI).
2. The medication will be provided to the staff member for safe storage *in locked medication bag* with precautions that the inhaler will be kept at room temperature (58-98 degrees), out of extreme cold and heat, and kept away from moisture or direct sunlight.
3. Staff members must have access to a phone.

Bus Precautions:

If quick relief medication is not available and the student requires treatment, driver will pull over and call 911.

Routine Home Asthma Medications (parent please complete)

Medication Name	Dose	When Taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

*****MUST HAVE MEDICATION AUTHORIZATION FORM ON BACK COMPLETED BY A PHYSICIAN*****

MEDICATION ORDERS

Name_____ DOB_____ ID/Grade_____

Severity Classification - Check one	**Triggers** - Check know triggers	**Any Exercise Modifications needed?**
___ Mild intermittent ___ Moderate persistent ___ Mild persistent ___ Severe persistent	___ Illness ___ Exercise ___ Strong emotions ___ Dust ___ Pollen ___ Strong odors/spray ___ Mold ___ Animals ___ Weather changes ___ Stress ___ Smoke ___ Extreme (hot/cold) ___ Ozone alert days ___ Foods_____ ___ Other_____	List _____

Medications

A. QUICK-RELIEF Medication Name | MDI or neb? | Dosage/Frequency

1. _____ _____ _____
2. _____ _____ _____

B. 5-15 min. BEFORE PE or EXERTION | MDI or neb? | Dosage/Frequency

1. _____ _____ _____

GREEN ZONE **Peak Flow_____** **Treatment - None**

Breathing is good, No cough or wheeze

YELLOW ZONE **Peak Flow_____to_____** **Treatment – Give QUICK RELIEF medicine**

Coughing, chest feels tight
Wheezing, feel short of breath

Call parent
If no improvement, go to RED ZONE

RED ZONE MEDICAL ALERT **Peak Flow_____to_____** **Treatment – Give QUICK RELIEF medicine, CALL 911**

Breathing is hard and fast

Trouble walking or talking
Nose wide open, ribs show

CALL PARENT
Repeat QUICK RELIEF medicine in 15 to 20 minutes if help has not arrived

Date administration to begin:_____

Date administration to end:_____

Adverse Reactions that should be reported to physician:

For the student for which it is prescribed: _____

_____

For the student for which it is prescribed: _____

_____

Self-Administer Authorization from Physician – check appropriate authorization

_____ As the prescriber I have determined that this student is capable of possessing and self-administering this inhaled asthma medication appropriately and have provided the student with training in the proper use of the inhaler.

_____ As the prescriber I have determined that this student **is not capable** of possessing and using this inhaled asthma medication appropriately and this medication should be administered by trained school personnel.

Prescriber Name _____ Phone Number _____

Prescriber Signature _____ Date _____ Emergency Number _____