Tri-County North Schools

AUTHORIZATION FOR ADMINISTRATION OF INHALED ASTHMA MEDICATION

(In accordance with ORC 3313.76/3313.4)

Parent Section

Student Name:_____ Birth_____ Date:_____
School:_____ Grade/Teacher: _____
Address:_____ Phone: _____
Home

As the Parent / Guardian of this student: ***I authorize*** ***Do not authorize*** *(circle one) my child to possess and self administer the 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. If self administration is not authorized, the administration of this prescribed medication may be administered by trained school staff. I have read and understand Tri-County North Schools Medication Policy.* ***I give permission for this information to be sent to the school via facsimile.***

Emergency contacts: name/relationship — Phone number (s)

1._____ 1._____ 2._____
2._____ 1._____ 2._____
3._____ 1._____ 2._____

Parent/Guardian name:_____ Date:_____
Parent/Guardian signature:_____ Phone _____
Work/cell

ASTHMA ACTION PLAN

What triggers your child's asthma attack (**check all that apply**):

- ☐ Illness
- ☐ Strong emotions
- ☐ Change in temperature
- ☐ Allergies ☐ cat ☐ dog ☐ dust ☐ mold ☐ pollen
- ☐ Cigarette or other smoke
- ☐ Exercise
- ☐ Indoor/outdoor pollution, odors
- ☐ Food_____
- ☐ Stress
- ☐ Chalk dust
- ☐ Other_____

Control of School Environment: List environmental control measures, pre-medications, and/or dietary restrictions the student needs to prevent an asthma episode: _____

Describe the symptoms your child experiences before or during an asthma episode (check all that apply):

- ☐ Cough, persistent
- ☐ Wheezing
- ☐ Shortness of breath or breathing hard/fast
- ☐ "Tightness" or pain in chest
- ☐ Irritability or agitation
- ☐ Runny nose
- ☐ Rubs/scratches chin/neck
- ☐ Complains of feeling tired/weak
- ☐ Other_____

Peak Flow Monitoring: Personal Best Peak Flow Number

Green Zone:_____ Yellow Zone:_____ Red Zone:_____

CALL 911 FOR:

- Rapid, labored breathing
- Pulling of skin of neck and chest with breathing and nasal flaring
- Can talk only in short, clipped sentences
- Blueness around mouth and nailbeds (paleness in children of color)
- Change in mental status (becoming agitated, anxious, declining consciousness)
- Sweaty, clammy skin

Home Medication (given daily and/or as needed):

Medication Name	Dose	When to Use
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

School Medications: **** MUST HAVE MEDICATION AUTHORIZATION FORM ON BACK COMPLETED BY PHYSICIAN****

Medication Name	Dose	When to Use
1._____	_____	_____
2._____	_____	_____

ASTHMA MEDICATION ORDERS

To be completed by Physician

Student Name_____ Birth Date_____

Name of Medication:_____
(one medicine per form)

Dose:_____ **Times to be given**:_____

Date administration is to begin:_____ to end:_____

Medication is to be administered for the following signs/symptoms:_____

_____

If needed how soon can medicine be repeated:_____

The medication cannot be repeated more than:_____

What procedure(s) should school personnel follow in the event that the inhaled asthma medication does not produce expected relief from the student's asthma attack:_____

_____

Adverse reactions that should be reported to physician:

- For the student for which it ***is prescribed***:_____

  _____

- For the student for which it is ***not prescribed*** who receives a dose:_____

  _____

Special instructions:_____

_____ 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. (Please consider providing a backup inhaler for the school clinic.)

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

Physician Name:_____ Phone number:_____

Fax number:_____ Emergency number:_____

Physician signature:_____ Date:_____