ASTHMA MEDICATION AUTHORIZATION AND TREATMENT ORDER

Omak School District **North** fax: 826-8166 **East** fax: 826-8231 **MS** fax: 826-7696 **HS** fax: 826-8515

Student:______________________________ Birth Date:____________________ Grade:________

Parent Section *Sección de Padres*

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.
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 give permission for my child to carry this medication. ☐ Yes/*sí* ☐ No
Doy permiso para que mi hijo/hija pueda cargar su medicamento.
I give permission for my child to self-administer this medication. ☐ Yes/*sí* ☐ No
Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.

I shall hold harmless and indemnify the school and Omak School District's officer, employees and agenda against all claims, judgments, or liability arising out of the self-administration and carrying of medication by my child.
Mantendré indemne e indemnizaré a la escuela y al funcionario, empleados y agenda del Distrito Escolar de Omak en contra de todas las reclamaciones, juicios o responsabilidades derivadas de la autoadministración y el transporte de medicamentos por mi hijo.

Signature/*Firma* ____________ Date/*Fecha* ____________ Phone #1 ____________ *Números de teléfonos* Phone #2 ____________

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW

Asthma Severity: ☐ Intermittent ☐ Persistent: ☐ Mild ☐ Moderate ☐ Severe
Usual Symptoms: ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asking to use inhaler ☐ Other ________
Triggers: ☐ Exercise ☐ Respiratory colds ☐ Pollens ☐ Animals ☐ Cold Air ☐ Smoke, chemicals, odors ☐ Other ________
Home Controller Medications/Dose/Frequency______________________________

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
☐ Other: ______________________________

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. ☐ 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* ____________

May, 2014