



Inhaled Medication Form _____ - _____

A new form must be completed each school year.

Student's Name _____ DOB _____ Grade _____

To be completed by Parent

I am the parent/guardian with legal custody of the above named student. I have read and understand the medication policy. I understand that the school employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I agree to abide by the medication policy and one of the following options (**one must be initialed**):

_____ I request my child be allowed to carry and self-administer the physician –ordered medication listed below. I understand my child and I are responsible for safeguarding the carried medication. I agree to provide the school with an additional supply of the medication ordered below, which can be administered by the school or my child in the event my child does not have his/her self-carried medication.

_____ I request a designated school employee administer my child's medications. I understand I will be notified if a school employee administers this medication.

Parent/guardian signature

Date

To be completed by Physician

Student's Name _____ Diagnosis _____

Medication Orders _____

One of the following options must be checked:

_____ In my professional opinion, it is medically necessary this student be allowed to carry and self-administer the above medication. I verify that this student has the knowledge and skills to safely administer and safeguard this medication.

_____ I authorize this medication to be administered by a designated school employee.

Physician's Name _____ Phone _____

Physician's signature _____ Date _____

Asthma Action Plan



General Information:

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/Health Care Provider _____ Phone numbers _____

■ Physician Signature _____ Date _____

Severity Classification

- Mild Intermittent Moderate Persistent
 Mild Persistent Severe Persistent

Triggers

- Colds Smoke Weather
 Exercise Dust Air pollution
 Animals Food
 Other _____

Exercise

1. Pre-medication (how much and when) _____

2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms

- Breathing is good
■ No cough or wheeze
■ Can work and play
■ Sleeps all night

Control Medications

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
■ Cough, wheeze or chest tight
■ Problems working or playing
■ Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 50 to 80% of personal best or
_____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days
 Change your long-term control medicines by _____
 Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- Take quick-relief treatment again
 Change your long-term control medicines by _____
 Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
■ Cannot work or play
■ Getting worse instead of better
■ Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 0 to 50% of personal best or
_____ to _____

Go to the hospital or call for an ambulance if

- Still in the red zone after 15 minutes
 If you have not been able to reach your physician/health care provider for help

Call an ambulance immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
 Lips or fingernails are blue