Asthma/ Quick Relief Bronchodilator Medication Authorization

Student Name: _____ Date of Birth: _____ Grade: _____

Known triggers: ☐ Exercise ☐ Upper Respiratory Infections ☐ Other:

HEALTH CARE PROVIDER SECTION:

Is student diagnosed with asthma or reactive airway disease? ☐ Yes ☐ No
Any ER visits or hospitalizations for asthma in last 1-2 years? ☐ Yes ☐ No

Preventative: Pre-treatment of medication and dose named below before strenuous activity:

- ☐ Routinely
- ☐ Upon request: Explain (weather, viral, seasonal, other):_____
- ☐ Not needed or not applicable

- May repeat in 4 hours if needed for additional or ongoing physical activity.

Other:

Mild to Moderate Symptoms:

1. For asthma episode/ breathing difficulty symptoms : Use this quick acting medication:

Albuterol ☐ 1 puff ☐ 2 puffs ☐ Other dose: _____ *(Albuterol = Proventil, Pro-Air & Ventolin)*

Other: _____
Medication name/ Dose/ Other such as per nebulizer if applicable

2. If symptoms return within a few hours, repeat above medication. Notify parent.

3. If symptoms continue but ARE NOT SEVERE, may repeat above medication once in 20 minutes. Notify parent.

Severe Symptoms: (continual coughing, struggling to breath, and/or trouble talking)

1. ☐ **2 puffs** ☐ **4 puffs** ☐ **6 puffs** of above inhaler medication ☐ **Other dose/med:**_____
Medication name/ Dose/ Other such as per nebulizer if applicable

2. CALL 911 then call parent and school nurse.

3. Repeat above dose if Emergency Medical Services have not arrived within 10 minutes.

☐ Permission for student to self-administer**:** I confirm this student has been instructed in the proper use of the medication listed above and is able to self-administer without school personnel supervision.

☐ Permission is **not given** for student to self-administer without supervision.

_____ _____ _____ _____
Sign*ature of Health Care Provider* (Physician, PA or APRN) **Date (valid for 12 months)** **PRINTED NAME** **Phone Number**

PARENT SECTION: Please sign below

FOR ALL STUDENTS

- I give my permission for my child named above to take the above medication at school as ordered.
- I understand that the medication will be given to my child or their use supervised by a school nurse or a school staff member unless the child has permission to self-medicate.
- I agree to doctor (health care provider) and school nurse communication based on this medical order/permission if needed. Communication, if needed, may only include the medication or treatment itself, implementation of the treatment in school and student outcomes of the treatment.
- I understand it is my responsibility to provide medication and to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.
- I understand that the schools may share this information to appropriate school personnel and classroom teachers.

⇨_____/_____
Parent or Guardian Signature **Date (valid for 12 months)**

FOR STUDENTS WHO HAVE HEALTH CARE PROVIDER PERMISSION TO SELF-MEDICATE:

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call. I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort. I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma emergency. I have provided backup medication. I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

⇨_____/_____
Parent or Guardian Signature **Date (valid for 12 months)**

***Office Use Only**: _____ Q order entry/ _____ Q 1st Aid handout attached/ _____ MAR in office/ _____ 1st aid handout w/ inhaler (4/16 form)*