

**ASTHMA MEDICATION PLAN** *(to be completed by the Student's Medical Provider)*

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

The above named person is a patient currently under my medical care. Due to a medical diagnosis of asthma, the medication listed below needs to be given during the regular school day according to the following protocol:

<p style="text-align: center;"><b>List Rescue Medication Name or Albuterol on line below:</b></p> <p>_____</p> <p>Medication dose ranges are not allowed at school. Please indicate a specific number of puffs to be given.</p>	<div style="background-color: black; color: white; padding: 2px;"><b>YELLOW ZONE – COUGHING, WHEEZING AND DIFFICULTY BREATHING!</b></div> <p><b>1ST</b> → For asthma symptoms at school, give Rescue Medication or Albuterol</p> <p><input type="checkbox"/> MDI #____ puffs    OR    <input type="checkbox"/> Nebulize #____ vial of _____ mg/3mL</p> <p>Directions: Give every 4-6 hours as needed</p> <hr/> <p><b>2ND</b> → If student continues to have symptoms, or condition worsens, call student's parent/guardian to notify use of medication &amp; report symptoms, then begin RED ZONE DIRECTIONS NOW.</p> <p>Yellow Zone Peak Flow Range: _____ to _____ <i>(Optional)</i></p>
<p><input type="checkbox"/> <b>PRETREATMENT BEFORE EXERCISE</b></p> <p>Give # _____ Puffs of Rescue Medication or Albuterol 5-15 minutes prior to PE, sports or strenuous exercise.</p>	<div style="background-color: black; color: white; padding: 2px;"><b>RED ZONE – BREATHING IS HARD &amp; FAST, HARD TO TALK OR WALK!</b></div> <p><b>1ST</b> → This is an Emergency, give Rescue Medication or Albuterol IMMEDIATELY</p> <p><input type="checkbox"/> MDI #____ puffs    OR    <input type="checkbox"/> Nebulize #____ vial of _____ mg/3mL</p> <p>Directions: Give every 20 minutes for up to 1 hour</p> <hr/> <p><b>2ND</b> → <b>Call 9-1-1</b> if no improvement after first Red Zone dose of medication!</p> <p>Call parent/guardian or emergency contact for student pick up.</p>
<p style="text-align: center;"><b>ASTHMA TRIGGERS</b></p> <p> <input type="checkbox"/> Colds      <input type="checkbox"/> Perfume/Cologne  <input type="checkbox"/> Dust      <input type="checkbox"/> Strong Smells  <input type="checkbox"/> Grass      <input type="checkbox"/> Weather Changes  <input type="checkbox"/> Pollen     <input type="checkbox"/> Other: _____         </p>	

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**RELEASE OF LIABILITY FORM** *(to be completed by the Student's Parent/Guardian)*

I, \_\_\_\_\_, the parent and/or legal guardian of

(Name of Child) \_\_\_\_\_ enrolled at (Name of School) \_\_\_\_\_

Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing for the term of one year.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR SCHOOL USE ONLY**

Date Asthma School Medication Form Expires: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Please be reminded form will expire one (1) year from date of physician's signature.**