Asthma Medication Administration Authorization Form

Asthma Actions Plan for / / to / / (not to exceed 12 months)

Triggers List:

Student's Name: | DOB: | Peak Flow (Personal Best):

ASTHMA SEVERITY: ☐ Exercise induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS FOR MEDICATION USE

GREEN ZONE: Long Term Control Medication- Use daily at home unless otherwise indicated.

- ☐ Breathing is good
- ☐ No cough or wheezing
- ☐ Can work, exercise, play
- ☐ Other:_____
- ☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency
(rescue medication)			

☐ Prior to exercise/sports/physical education

If using more than twice per week for exercise, notify the healthcare provider and parent/guardian.

YELLOW ZONE: QUICK RELIEF MEDICATION - to be added to Green Zone medications for symptoms.

- ☐ Coughing or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other:_____
- ☐ Peak flow between _____ &_____ (50%-79% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in _____ minutes, notify the healthcare provider and parent/guardian.
If using more than twice per week for exercise, notify the healthcare provider and parent/guardian.

RED ZONE: EMERGENCY MEDICATION - Take these medications and call 911.

- ☐ Medication is not helping within 15-20 minutes
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or skin retracts between ribs
- ☐ Lips of fingernails are blue
- ☐ Trouble walking or talking
- ☐ Other:_____
- ☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize self-carry and/or self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs.

Student may self-carry medications (school aged children): [ ]Yes [ ]No

Prescriber signature: _____ Date:_____ Parent/Guardian signature: _____ Date:_____

Reviewed by Child Care Provider

Name(printed):_____ Signature: _____Date:_____