ASTHMA Medication Authorization and Treatment Plan

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

LICENSED HEALTH PROFESSIONAL (LHP) Treatment plan for managing asthma at school:

Severity of asthma: ☐ mild ☐ moderate ☐ severe ☐ exercise-induced

Activity modifications or restrictions: _____

Medication	Dose, Time, and Mode of Administration
☐ _____ Inhaler ☐ with spacer	☐ _____ puffs by mouth every _____ hours as needed for symptoms: coughing, wheezing, _____ ☐ _____ puffs by mouth 5-20 minutes prior to exercise. ☐ If no relief _____ minutes after treatment, **call 911** and parents. ☐ Other:
☐ _____ by Nebulizer ☐ mouthpiece ☐ mask	☐ 1 unit dose every _____ hours as needed for symptoms: coughing, wheezing, _____ ☐ Other:
☐ Use peak flow meter per attached directions	

Student has been instructed in use of device needed to administer medication. ☐ yes ☐ no

Student recognizes symptoms of asthma and is capable of seeking assistance if needed. ☐ yes ☐ no

Student has demonstrated the skill level necessary to use the medication appropriately without supervision. ☐ yes ☐ no

Student may carry and self-administer the medication ordered above. ☐ yes ☐ no

_____

_____ _____

Date of Signature *Licensed Health Professional*

_____/_____ _____

Phone *FAX* *Name (Print)*

PARENT or GUARDIAN
To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

My child can carry and self administer this medication at school ☐ yes ☐ no

If I give permission for my child to carry and self-administration medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

_____ _____

Date of Signature *Parent/Guardian Signature*

_____ _____

Home Phone *Work or Cell Phone*

Reviewed by RN/LPN:_____ on ___/___/___