

Asthma Action Plan Medication Authorization & Self-Administration Form in accordance with UCA 53A-11-602 Utah Department of Health/Utah State Office of Education	School Year:	Picture
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STUDENT INFORMATION			
Student:	DOB:	School:	Grade:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax:	
School Nurse:	School Phone:	Fax:	

History of anaphylaxis where epinephrine was used?
 Yes (please also complete IHP104.1 form)--allergy to: _____ No

PHYSICIAN TO COMPLETE

Green Zone: Doing Great!	
Student has ALL of these: <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can sleep all night Able to work and play normally 	Controller (preventive) medications <u>taken at home</u> : Medication: _____ Dose: _____ When: _____ Medication: _____ Dose: _____ When: _____ Medication: _____ Dose: _____ When: _____ Avoid these asthma triggers: <input type="checkbox"/> Dust <input type="checkbox"/> Pet dander <input type="checkbox"/> Colds <input type="checkbox"/> Tobacco smoke <input type="checkbox"/> Mold <input type="checkbox"/> Exercise <input type="checkbox"/> Strong odors <input type="checkbox"/> Pollen <input type="checkbox"/> Inversions <input type="checkbox"/> Other: _____ Take quick-relief medication (see medication order in Yellow Zone): <input type="checkbox"/> Before exercise/exposure to a trigger When: _____ <input type="checkbox"/> Other: _____ When: _____

Yellow Zone: Caution!

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Student has ANY of these: <ul style="list-style-type: none"> Coughing or wheezing Tight chest Shortness of breath Waking up at night 	Quick-relief medication with spacer (if available): <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 50%;">Medication</th> <th style="width: 25%;">Dose</th> <th style="width: 25%;">Interval</th> </tr> </thead> <tbody> <tr> <td>Inhaler:</td> <td></td> <td></td> </tr> <tr> <td>Nebulizer:</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> </tbody> </table> Possible side effects: _____	Medication	Dose	Interval	Inhaler:			Nebulizer:			Other:		
Medication	Dose	Interval											
Inhaler:													
Nebulizer:													
Other:													

Parent should contact Healthcare Provider below if 1) quick-relief medication is needed more often than every 4 hours, or needed every 4 hours for more than a day or 2) there is no improvement after taking medication.

Red Zone: Emergency!

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Student has ANY of these: <ul style="list-style-type: none"> Can't eat or talk well Breathing hard and fast Medicine isn't helping Rib or neck muscles show when breathing in 	<p>Call 911 for an ambulance or go directly to the emergency department</p> <input type="checkbox"/> Repeat quick-relief medication every 20 minutes until medical help arrives. <input type="checkbox"/> Other: _____ Parent should contact Healthcare Provider below while providing treatment.

PRESCRIBER TO COMPLETE

The above named student is under my care. The above reflects my plan of care for the above named student.

It is medically appropriate for the student to self-carry asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times. The medication(s) prescribed for this student is/are identified above.

It is **not** medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.

Healthcare Provider (print)	Signature	Date
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PARENT TO COMPLETE

Parental Responsibilities:

- The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.
- If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before the designated staff can administer the updated asthma medication prescription.

Parent/Guardian Authorization

- I authorize my child to self-administer and carry the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53A-11-602. My child and I understand there are serious consequences for sharing any medication with others.
- I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.
- I authorize the appropriate/designated school personnel maintain my child's medication for use in emergency.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and held harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the asthma action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name (print)	Signature	Home Number	Cell Number
Emergency Contact	Relation	Home Number	Cell Number

SCHOOL NURSE (or principal designee if no school nurse)

- Signed by physician and parent (part 1 and 2)
 - Medication is appropriately labeled
 - Medication log generated
- Inhaler is kept: Student Carries Backpack In Classroom Health Office Front Office Other: _____

Asthma Emergency Action Plan distributed to need to know staff:

- Teacher(s)
- PE teacher(s)
- Transportation

School Nurse Signature _____

Date _____