ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade_____

❒ School E-mail _____ ❒ School Fax (___) _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____

Phone (Cell) _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Asthma Care Provider _____ ❒ Office Phone (___) _____

❒ Office E-mail _____ ❒ Office Fax (___) _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

	MONITORING	TREATMENT
RED	**RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness **RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone	• Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW	**YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ❒ 2 ❒ 3 days, if symptoms remain improved • If symptoms are not gone after ❒ 2 ❒ 3 days, move to the **RED ZONE**
GREEN	**GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before Exercise ❒ Recess ❒ PE/Sports *(not to exceed every 4 hours)*
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

❒ Administer medications as instructed above

❒ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school

❒ Student needs supervision or assistance to use his/her inhaler medication

❒ Student should **NOT** carry his/her inhaler while at school ❒ Have student use spacer with inhaler medication

_____ _____ _____

ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**

IN-SCHOOL MEDICATION PERMISSION FORM

Administration of medication at Canterbury School is done for students with chronic health conditions ONLY. The school is not equipped to administer antibiotics, cough medicine, decongestants or other over-the-counter prescription medications. Indiana state law requires that schools observe certain regulations in administering this medication. We appreciate your cooperation in abiding by the mandates required by the state of Indiana and approved by the Canterbury School administrators, which are as follows:

1. Prescription medications MUST be in the original container. The label will meet the requirement for a physician's signature; however, the parent must complete and sign the Student Medication Permit below. A new container and another permit must accompany any changes in the dosage to be administered.
2. Bring in the amount of medication needed for one month. The student's name, the name of the medication and the amount to be administered must be on the bottle. Students must also have a daily dispenser for their medication.
3. The PARENT/LEGAL GUARDIAN ONLY may bring medication to school and give to the school nurse. Please **DO NOT** send any medication with students. **No student will be permitted to have any medication in his or her possession at any time, with only minimal exception for emergency medications which must be pre-authorized with the school nurse.**
4. Medication administration may be done by a designated non-medically trained staff member under the direction of a registered nurse. Indiana law states, "A person administering medication to a pupil is not liable for child damages as a result of the administration except for an act or omission amounting to gross negligence of willful and wanton misconduct."
5. Inhalers and epinephrine injectors may be kept in applicable locations for emergency use; however, ALL OTHER medication will be locked in a designated space.

Your child's health and safety are our first concern. Thank you for your cooperation in keeping Canterbury School a safe environment for all our students.

Tammy Eilers, RN
Canterbury School Nurse

Student's Name: _____Grade:_____

MEDICATION 1: Name of Medication: _____ Given for: _____
Time and dosage_____
MEDICATION 2: Name of Medication: _____ Given for: _____
Time and dosage_____
MEDICATION 3: Name of Medication: _____ Given for: _____
Time and dosage_____

Please initial one of the following:

_____ A parent or guardian will pick up the medicines at the end of the school year.

_____ I give consent for the above medicines to be returned to my child at the end of the school year to take home.

LEGAL GUARDIAN'S
SIGNATURE_____Date:_____