

**ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN**

<b>PARENT/GUARDIAN: Complete and Sign this portion and the medication authorization below</b>		<b>Today's Date:</b>
Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	
<b>1 KNOWN ASTHMA TRIGGERS:</b> <input type="checkbox"/> Exercise <input type="checkbox"/> Pet Dander <input type="checkbox"/> Mold <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Colds <input type="checkbox"/> Strong Odors <input type="checkbox"/> Cold Air <input type="checkbox"/> Pests		
<b>2 ALLERGIES:</b> _____		

**HEALTH CARE PROVIDER: COMPLETE ALL ITEMS BELOW, SIGN AND DATE. THANK YOU!**  
**Asthma Medication(S) To Be Given:**

**Student's Asthma Severity Classification:**  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

**A** Exercise Pre-treatment:  Not Required  Before Recess  Before PE/Sports

Give: Albuterol MDI 90 / Xopenex MDI 45 \_\_\_\_\_ Puffs Inhaled (by mouth)  10-15 minutes before exercise  with spacer  
**(Circle One)**

Nebulized Albuterol 2.5mg/Xopenex 0.63mg \_\_\_\_\_ Vial inhaled (by mouth)  10-15 minutes before exercise  with nebulizer

OTHER: \_\_\_\_\_

**B** RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING  
 (Follow CAUTION or DANGER ZONES of Asthma Action Plan)

Give **(Circle One)**:

Albuterol MDI 90 / Xopenex MDI 45 \_\_\_\_\_ Puffs Inhaled (by mouth)  every \_\_\_ hours  with spacer

Nebulized Albuterol 2.5mg **OR** \_\_\_\_\_ Vial inhaled (by mouth)  every \_\_\_ hours  nebulizer  
 Nebulized Xopenex 0.63mg

OTHER: \_\_\_\_\_

**\* If there is no improvement 20 minutes after taking the Rescue Medication: Notify provider**

**HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a**

**3** Side Effect(s) to watch for: Nervousness, Shaking, Palpitations, Headache \_\_\_\_\_ or  None

**4** Reaction to/or negative interaction with food or drugs: \_\_\_\_\_ or  None

**5** Self-Administration Authorization:  This student is capable to safely and properly self-administer medication(s)  
**OR**  This student is not approved to self-administer medication(s)

**6** Medication Start/End Dates (one year max)  
 Start: \_\_\_/\_\_\_/\_\_\_ End: \_\_\_/\_\_\_/\_\_\_

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone # \_\_\_\_\_  
**(ADD STAMP with Address and Phone)**

**PARENT/GUARDIAN CONSENT :**

I authorize the student to possess and self-administer medication as described and directed above

I authorize this medication to be administered by school personnel as described and directed above

I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.

I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

I assume full responsibility for providing the school with the prescribed medication and spacer.

I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Individual Receiving Written Authorization and Medication \_\_\_\_\_ Title/Position: \_\_\_\_\_  
 (PRINT & SIGN)

