MISD Student Asthma Action Plan & Medication Authorization

Student Name: _____DOB_____ ID: _____ Grade: _____Teacher:_____

Identifiable Triggers for this Child:

	Exercise		Strong Odors/fumes		Respiratory Infections		Food:
	Animals		Pollens		Changes in Temperature		Allergies:
	Carpet		Molds		Chalk Dust		Other:

Medication for Asthmatic Episode:

☐ Give Inhaler _____ puffs every _____ hours Special Instructions:
☐ Give Nebulizer medication: _____ vial every _____hours _____ vial every _____hours Special Instructions:

Have student resume activities if: _____

Contact Parent if: _____

Seek Emergency treatment for the following:

	No improvement 15-20 minutes after initial treatment and emergency contact cannot be reached				
	Peak flow of:		Hard time breathing		Child is hunched over
	Trouble Walking or Talking		Chest and neck pulled with breathing		struggling to breath
	Lips or fingernails are grey or blue		stops playing and can't start activity again		
	Other:				

☐ **PEAK FLOW MONITORING:**

Personal Best Number:_____ Monitoring Times: _____ _____ _____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from this medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know.

I understand that the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

☐ I authorize _____ to carry and use his/her inhaler medication at school.

☐ I do **NOT** authorize _____ to carry his/her inhaler medication while at school.

Physician's Name: _____**Telephone Number:** _____

Physician's Signature: _____ **DATE:** _____

Parent/Guardian Signature _____ Date:_____

_____ _____ _____

Parent Telephone Number | Emergency Contact Name | Emergency Telephone Number

_____ _____

Student Signature (if authorized to carry his/her medication at school) | Date

_____Student Demonstrates knowledge of proper use, dose, time and school policy regarding the responsibility of carrying medication on his/her person.

_____ _____

Nurse Signature | Date

STUDENT NAME: ____

Inhaler Location/s: Clinic ☐ Trainer/Coach ☐ On his/her person ☐

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Signature:________________________________ Initials ________ Signature: __________________________________Initials: ________

Signature: ________________________________ Initials ________ Signature: __________________________________Initials: ________

Signature: ________________________________ Initials ________ Signature: __________________________________Initials _________