Asthma Action Plan/Medication Authorization Form

For all children with asthma

Mecklenburg County Health Dept.

Student Name _____ **CMS Student ID#** _____
School/Year _____ **Grade/Teacher** _____
Parent/Guardian _____ **Contact Number (H)** _____ **Cell** _____ **Work** _____
Physician's Name _____ **Physician Phone Number** _____ **Fax** _____

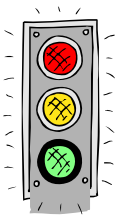
1. **NO SMOKING in your home or car, even if your child is not with you.**
2. Always use a spacer with inhalers (MDIs).
3. Shake inhaler before every spray (puff).
4. Remove, control and stay away from known triggers in your child's environment.
5. Clean plastic part of inhaler weekly using package directions.
6. Prime inhaler after opening and before use if not used in more than two weeks. Proair-three puffs, all others four puffs.

Child's triggers are: *(circle or check all that apply to your child)*

☐ Respiratory infections or flu	☐ Mold	☐ Pollen	☐ Dust, dust mites
☐ Weather/temperature changes	☐ Indoor pets	☐ Exercise	☐ Strong odors or sprays
☐ Indoor/outdoor pollution	☐ Household cleaners	☐ Strong emotion	☐ Cockroaches
☐ Smoke	Other allergies_____		

GREEN ZONE – ALL CLEAR – GO! | USE CONTROLLER MEDICINES

ASTHMA IS WELL CONTROLLED ☐ **No controller medicine needed at this time**



You should have:

- No wheezing
- No coughing
- No chest tightness
- No waking up at night because of asthma
- No problems with play because of asthma
- **Peak flow number from _____ to _____**

Medicine	Method	How Much	How often
_____	_____	_____	_____times per day
_____	_____	_____	_____times per day
_____	_____	_____	_____
_____	_____	_____	_____

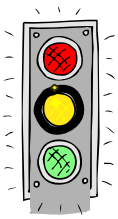
15 minutes before exercise use _____ puffs (inhaled) _____

*Rinse child's mouth after using inhaled steroids (daily/controller medicines).

YELLOW ZONE – CAUTION! – TAKE ACTION | TAKE QUICK RELIEF MEDICINE

ASTHMA GETTING WORSE

Continue to use green zone daily medicines and add:



You may have:

- Coughing
- Wheezing
- Chest Tightness
- First signs of a cold
- Coughing at night
- **Peak flow number from _____ to _____**

Medicine	Method	How much	How often
Albuterol/Xopenex	inhaled	____puffs OR ____vial	Every ___hours prn

_____May repeat after 20 minutes x 1 (Indicate with check)

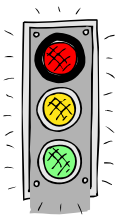
Also take:

_____ _____ _____ _____

If yellow zone symptoms continue for 24 hours or child needs extra rescue medicine more than 2 times per week, call your child's doctor.

RED ZONE – STOP! – GET HELP NOW! | TAKE QUICK RELIEF MEDICINE

THIS IS AN EMERGENCY!



You may have:

- Quick relief medicine that is not helping
- Wheezing that is worse
- Faster breathing
- Blue lips or nail beds
- Trouble walking or talking
- Chest and neck pulled in with each breath
- **Or Peak flow less than _____**

Continue to use green zone medicines and do the following:
Use _____ puffs or 1 vial Albuterol/Xopenex inhaled every 20 minutes for a total of _____ doses.

CALL DOCTOR NOW! If you cannot reach doctor, **CALL 911** or go directly to the **EMERGENCY ROOM**
DO NOT WAIT!

Physician Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

School Health Nurse Signature _____ **Date**_____

(SCHOOL NURSE USE ONLY) Student self carries inhaler Y/N Inhaler in the Health Room Y/N Inhaler in classroom Y/N **CI 45** 3/09

AUTHORIZATION FOR SELF-MEDICATION BY CMS STUDENTS

Student's Name_____ Birthdate_____

Medication_____for _____

Eligibility: In accordance with CMS Policy JLCD, Administering Medications to Students, and its accompanying regulation, JLCD-R, only students who meet the following descriptions may possess and self-administer medications: (1) Students with special medical needs such as asthma and/or severe allergies or who are subject to anaphylactic reactions and may require emergency medications (i.e., asthma inhaler or epinephrine auto-injector ["Epi-pen]); and (2) Students who require frequent administrations of non-prescription medications or prescription medications that are not controlled substances.

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Healthcare Provider: The student named above has (1) asthma or an allergy that could result in an anaphylactic reaction and may require emergency medications; or (2) a condition that requires frequent administration of a prescription or non-prescription medication. The medication is not a controlled substance. This student is capable of, has been instructed on the procedures for and has demonstrated the skill to self-administer this medication as directed on page 1 of this form. Please allow him/her to self-administer the medication during school hours and as otherwise indicated on page 1 of this form.

This student will not require adult supervision while taking this medication.

Physician signature/date_____

Parent/Guardian: I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. If the medication that is prescribed for my child is for the treatment of asthma or anaphylactic reactions, I agree to provide a supplementary supply of the medication that will be kept by the school in a location to which my child has immediate access. I absolve the Charlotte-Mecklenburg Board of Education and their agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medication at school. I further consent for the information about my child included on pages 1 and 2 of this form to be shared with appropriate school staff as necessary for the safety of my child.

Parent signature/date _____

Student: I am capable of taking this medication as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to discipline under the Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school sponsored activities. Unless the medication is prescribed for the treatment of asthma or anaphylactic reactions, I understand that I will lose the privilege of self-administering my medication if I do not follow these rules.

Student signature/date _____

School Nurse: I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication. I have informed this student that he or she must tell an appropriate staff member whenever he or she has used the medication at school.

Nurse signature/date _____