School Asthma Action Plan/Medication Authorization Form

Mecklenburg County Public Health

School Name	School Phone #	Fas:	For School Use Only
		(704) 432-2079 (School Health)	**Date Received/Receiver's Signature:** **Medication Received?** ❒ yes ❒ no
Student's Name (Please print.)	**Student's Date of Birth**		**Date Approved/Nurse's Signature** **Entered in EHR?** ❒ yes ❒ no

Parent/Guardian: Please read the completed action plan. Sign, initial and date this page. Initial and date the bottom of the healthcare providers orders to show your agreement.	• **Student Self Carries** • **Inhaler in Health Room** • **Inhaler in Classroom**

Important Information about Medication Admininstration in CMS Schools

☐ ☐ ☐ ☐	When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged. Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCDR). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions. Unless changed in writing, this plan will be used for the entire school year within which it was written. Medications are given by a nurse or trained CMS staff.	☐ ☐ ☐ ☐ ☐	No medication will be given at school until this authorization has been approved by a school nurse. New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications. Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use. Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.

Healthcare Provider's Name / Address / Phone / Fax (please print or use stamp)		**Parent/Guardian Contact Information (please print)**	
	Parent/Guardian		
	Phone:		Phone:
	Parent/Guardian		
	Phone:		Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools" in this action plan. I give permission for my child to receive the medications noted in this plan during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that

may result from my child taking this medication at school.

Write on line below.

Parent's/Guardian's Name (print) Signature Initials Date

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Student's Name:	**Student's Date of Birth:**

To be completed by healthcare provider.
In addition to this form, complete the authorization for self-medication if student will self-carry and/or self-medicate.

Check Asthma Severity Classification: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Is student using peak flow? ❑ Yes, personal best is _____. ❑ No

Student's Triggers: Check all that apply.			
• Respiratory infections/flu ❑ Indoor/outdoor • Weather/temperature pollution changes ❑ Mold	❑ Indoor pets ❑ Household cleaners	• Pollen • Exercise • Smoke	• Strong emotions ❑ Cockroaches • Dust/dust mites ❑ Strong odors or sprays
Other Triggers:			
GREEN ZONE – Doing well			**Use controller medicine daily as ordered.**

Signs/Symptoms: Breathing normal. No coughing,wheezing, chest tightness. Can work or play without asthma symptoms. Sleeping well at night without asthma. If using peak flow, peak flow number _____ to _____ (80% or more of personal best).

Medicine	**Method How much? When / how often? Take at:**
_____	☐Home _____ _____ _____ ☐School

_____	□ Home _____ _____ _____ □ School

For exercise-induced asthma, provide instructions below (specify medicine, how much, when).

_____

Side Effects / Adverse Reactions Green Zone Medications:	

YELLOW ZONE – Caution	**Take quick relief medicine. Continue green zone controller medicine at times ordered.**

Signs/Symptoms: One or more of the following – Some problems breathing. Cough, wheeze or chest tight. Problems working or playing due to asthma symptoms. Waking at night due to asthma symptoms. First signs of a cold. If using peak flow, peak flow number _____ to _____ (between 50% and 79% of personal best). If yellow zone symptoms continue for 24 hours or child needs extra rescue medicine more than 2 times a week, contact doctor.

□ **Albuterol**	Administer _____ puffs (or) _____vial	_____ May repeat after 20 minutes x 1	Every _____ hours PRN

Side Effects / Adverse Reactions Yellow Zone Medications:	

RED ZONE – Get help NOW! Call 911!		**Take quick relief medicine. Continue green zone controller medicine at times ordered.**

Signs/Symptoms: One or more of the following – Lots of problems breathing. Medicine is not working; symptoms getting worse. Chest and neck pulled in with each breath; trouble walking/talking due to shortness of breath; blue lips or fingernails. If using peak flow, peak flow number _____ to _____ (between less than 50% of personal best).

□ **Albuterol**	Administer _____ puffs (or) _____ vial inhaled every 20 minutes for a total of _____ doses.

Side Effects/Adverse Reactions for Red Zone Medications: Same as Yellow Zone.

In my professional opinion, it is medically necessary for this student to receive the medication(s) noted above during school hours.

Healthcare Provider's Name (print) Signature Date

For parent/guardian: I approve this asthma action plan. Parent's/Guardian's Initials/Date: _____/_____