# Asthma Medication Administration Authorization Form

**ASTHMA ACTION PLAN for**

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Name</th>
<th>DOB</th>
<th>PEAK FLOW PERSONAL BEST</th>
</tr>
</thead>
</table>

**ASTHMA SEVERITY:**
- □ Exercise-induced
- □ Intermittent
- □ Mild Persistent
- □ Moderate Persistent
- □ Severe Persistent

**List Triggers:**

<table>
<thead>
<tr>
<th>Green Zone: Long Term Control Medication — use daily at home unless otherwise indicated</th>
</tr>
</thead>
</table>
| □ Breathing is good  
□ No cough or wheeze  
□ Can work, exercise, play  
□ Other: ___________________________  
□ Peak flow greater than ________ (80% personal best) |

**Yellow Zone: Quick Relief Medications — to be added to Green zone medications for symptoms**

<table>
<thead>
<tr>
<th>□ Prior to exercise/sports/ physical education</th>
</tr>
</thead>
</table>
| (Rescue Medication)  
If using more than twice per week for exercise, notify the health care provider and parent/guardian. |

<table>
<thead>
<tr>
<th>Red Zone: Emergency Medications — Take these medications and call 911</th>
</tr>
</thead>
</table>
| □ Medication is not helping within 15-20 mins  
□ Breathing is hard and fast  
□ Nasal flaring or skin retracts between ribs  
□ Lips or fingernails blue  
□ Trouble walking or talking  
□ Other: ___________________________  
□ Peak flow less than ________ (50% personal best) |

**Health Care Provider and Parent Authorization with Review by RN**

**Review by RN**

<table>
<thead>
<tr>
<th>Reviewed by DN/RN Health Supervisor</th>
</tr>
</thead>
</table>
| Name: ___________________________  
Signature/date: ___________________ |

**Parent/Individual/Guardian signature and date:**

| Parent/Individual/Guardian signature: ___________________________  
Prescriber signature & date: ___________________________ |

By signing below, I certify that the student is authorized to self-carry/self-administer medication at school/camp and authorize the student to self-carry/self-administer the medications indicated during school or camp.

| Prescriber signature & date: ___________________________  
Parent/Individual/Guardian signature: ___________________________ |

I authorize the school/camp staff to administer the above medications as indicated. Student may self-carry medications (School-age students only) □ Yes □ No

| Prescriber signature & date: ___________________________  
Parent/Individual/Guardian signature and date: ___________________________ |
Prevention Plan

Student’s Name: ___________________________ DOB: __________ Room #: _______ Teacher’s Name: ________________

ALLERGY TO: ____________________________________________________________

__________________________________________________________

Asthmatic? Y/N) ____________________________________________________________ (Yes=Higher Risk for Severe

Reaction)

School will:
☐ Have a Certified Medication Technician on site with an on-call Delegating RN
☐ Have staff trained in CPR & First Aid
☐ Have staff trained in Allergy & Anaphylaxis → administering EpiPen® including demonstration & practice
☐ Emergency List distributed to: ____________________________
☐ Have staff trained on individual emergency plans
☐ School staff will make every reasonable effort to prevent the student’s exposure to known allergens
☐ Other: ________________________________________________________

Parents will:
☐ Provide pertinent health information to the school
☐ Provide Physician Authorization Forms and Action Plans → for student medication and specific actions plans for emergency care
☐ Current, non-expired medications
☐ Provide safe snack option to school/classroom
☐ Other: ________________________________
☐ Other: ________________________________
☐ Other: ________________________________

Student will:
☐ Make every effort to avoid contact with allergen
☐ Alert nearest adult if suspect exposure to allergen
☐ Other

Notes: ________________________________