ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

PARENT/GUARDIAN: Complete and Sign this portion and the medication authorization below		Today's Date:
Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	

① **KNOWN ASTHMA TRIGGERS:** □ Exercise □ Pet Dander □ Mold □ Dust □ Pollen □ Colds □ Strong Odors □ Cold Air □ Pests

② **ALLERGIES:** _____

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

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

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

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

OTHER: _____

Ⓑ **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)

Nurse (if applicable):_____

Note: This form is a sample in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v).