McALLEN ISD

School Year_____

Asthma Medication Authorization Permit & Asthma Action Plan

Student Name: _____ID#_____ DOB _____ Grade_____

Emergency Contact: _____ Home/Cell Ph# _____

TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis: Asthma Chronic bronchitis Other: _____

Triggers: _____

PE Restrictions: _____

1. **Regular Medications Green Zone:** _____ _____ _____
   - _____ _____ - give _____ puffs every _____ minutes before exercise
2. **Rescue Medications for mild symptoms (Yellow Zone)**
   - _____ / _____ give _____puffs every _____ hours as needed for asthma symptoms
   - Other: _____
3. **Rescue Medications for acute asthma (Red Zone)**
   - _____/_____ give _____puffs every _____minutes as needed for asthma symptoms (max amount _____ per hour)
   - Prednisolone: _____ mL; every _____ Other _____
   - I have instructed the student on the proper way to use his/her inhaler. This student is both capable of carrying & self-administering an inhaler. ☐Yes ☐ No

Physician's Name (print): _____ Physician's Signature: _____

Address: _____ City/Zip: _____ Phone: _____

School Emergency Plan

ASTHMA ACTION PLAN	
GREEN ZONE Symptoms: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities.	
YELLOW ZONE Symptoms: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions.	**ACTION FOR SCHOOL** 1. Give Rescue Medication(s) listed above 2. Notify parent if symptoms are NOT relieved by meds after 15-20 mins. 3. If symptoms are NOT RELIEVED follow **School Emergency Plan** below. 4. If symptoms are relieved, the student may return to class *Notify the Parent if the rescue inhaler has been used more than two times this week (not related to physical activity).
RED ZONE Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restriction, symptoms are the same or worse after 30 minutes in Yellow Zone.	**ACTION FOR SCHOOL** 1. Give Rescue Medications listed above 2. If symptoms are NOT improved within 15 to 20 minutes by the student's Rescue Medication, or if symptoms worse, follow **School Emergency Plan** below.

1. Repeat Rescue medication(s) NOW
2. Call 911- Seek medical care if minimal or no improvement
3. Contact parent/guardian
4. REPEAT Rescue medication(s) in 20 minutes if help has not arrived and symptoms have NOT improved
5. Stay with the student until paramedics arrive

Parent/Guardian:

Your signature gives permission for the nurse to implement the above medical orders, contact and receive additional information from your health care provider regarding the medical condition(s), the prescribed medication(s) and create a care plan to be shared with your child's teachers. *Su firma da permiso a la enfermera para implementar las ordenes medicas descritas arriba, ponerse en contacto y recibir información adicional de su proveedor medico acerca de la condición médica(s), medicamentos recetados y crear un plan de atención para compartir con los maestros de su hijo(a).*

Signature of Parent/ Guardian: _____ **Phone #:** _____

For self-carry and self-administer students only

I have been instructed on the proper use of my prescription-labeled inhaler and fully understand how to administer this medication. I will not allow another student to use my prescription inhaler under any circumstances. I also understand that should another student use my prescription-labeled inhaler, the privilege of carrying it with me may be revoked. I also accept the responsibility for checking in with the nurse to keep him/her informed of the use of my inhaler in case I start having problems with my asthma.

Student's Name (print): _____ Student's Signature: _____ Date_____