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: ___/___/___
one school year only

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).