

ASTHMA Medication Authorization and Treatment Plan

Student Name: _____ Birth Date: _____
 School: _____ Grade: _____

LICENSED HEALTH PROFESSIONAL (LHP) Treatment plan for managing asthma at school:

Severity of asthma: mild moderate severe

Activity modifications or restrictions: _____

Medication	Dose, Time, and Mode of Administration
<input type="checkbox"/> _____ Inhaler <input type="checkbox"/> with spacer	<input type="checkbox"/> _____ puffs by mouth every _____ hours as needed for symptoms: coughing, wheezing, _____ <input type="checkbox"/> _____ puffs by mouth 5-20 minutes prior to exercise. <input type="checkbox"/> If no relief _____ minutes after treatment, call 911 and parents. <input type="checkbox"/> Other:
<input type="checkbox"/> _____ by Nebulizer <input type="checkbox"/> mouthpiece <input type="checkbox"/> mask	<input type="checkbox"/> 1 unit dose every _____ hours as needed for symptoms: coughing, wheezing, _____ <input type="checkbox"/> Other:
<input type="checkbox"/> Use peak flow meter per attached directions	

- Student has been instructed in use of device needed to administer medication. yes no
- Student recognizes symptoms of asthma and is capable of seeking assistance if needed. yes no
- Student has demonstrated the skill level necessary to use the medication appropriately without supervision. yes no
- Student may carry and self-administer the medication ordered above. yes no

Date of Signature

Licensed Health Professional

Phone / FAX

Name (Print)

PARENT or GUARDIAN To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

My child can carry and self administer this medication at school yes no

If I give permission for my child to carry and self-administration medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

Date of Signature

Parent/Guardian Signature

Home Phone

Work or Cell Phone