



Dear Parent/Guardian,

Our records indicate that your student has a history of **Asthma**. To ensure their safety at school, the following forms must be completed and submitted to the school nurse each year if your child requires emergency rescue medication (ex: rescue inhaler) at school or will self-carry/administer their medication:

- 1. Authorization for Medication to be Taken During School Hours (HEA-F062):** A separate form must be completed for each medication and signed by the parent/guardian and physician (for prescription medications) to authorize administration during school hours.
- 2. Asthma Emergency Action/Health Plan (HEA-F036):** The school nurse will refer to the physicians' orders in collaboration with parent/guardian input to complete this form.

We appreciate your time in completing these forms, as they are essential in ensuring your child's safety while they receive the best possible education.

If you have any questions or need assistance completing these forms, please contact your school nurse.

**AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS**

**PLEASE NOTE** : Medications must be brought to school by a parent/guardian. Students may not self carry medication at school unless it is an emergency rescue medication that must remain with the student at all times, and is indicated by the prescriber below. Prescription medication must be in a properly labeled prescription bottle with the student's name, pharmacy name and phone number, date (within current school year), prescriber's name, name of medication, dose, and frequency on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients. Medications must be picked up by a parent/guardian at the end of the school year or they will be discarded.

**The following section is to be completed by the PARENT/GUARDIAN:**

<b>School:</b>	<b>Student's Name:</b>	<b>Date of Birth:</b>
<p>I request that my child be assisted in taking medication, described below, at school by legally authorized persons or permitted to medicate himself/herself as also authorized by my child's physician. I give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency with my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials. I, will assume any and all responsibility and liability, and release CMCSS and its personnel from any legal claims arising out of medication taken at school.</p>		
_____	_____	(____) _____
<b>Date</b>	<b>Parent/Guardian Name</b>	<b>Parent/Guardian Signature</b>
		<b>Emergency Phone</b>

**PARENT APPROVAL OF SELF CARRY/SELF ADMINISTRATION OF EMERGENCY RESCUE MEDICATION ONLY** (EPI, asthma relief inhaler)  
 Provider must indicate below and self-carry privileges may be revoked if the school nurse determines they are misusing the medication, sharing the medication, or found incapable of properly administering.

**Parent intitial for emergency rescue medication only:** \_\_\_\_\_ **I DO** \_\_\_\_\_ **I DO NOT** request my child be permitted to self carry and self administer emergency medication as ordered by the healthcare provider.

**The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter Medications**

<b>Name of Medication:</b>	
<b>Diagnosis for which medication is prescribed:</b>	
<b>Route:</b>	<b>Dose:</b>
<b>If medication is to be given daily, at what time?</b> (please consider alternate dosing schedule to minimize medication in school)	
<b>If medication is to be given "when needed" describe indications:</b>	
<b>How soon can it be repeated?</b>	<b>Length of time treatment recommended?</b>
	___ Current School Year ___ Other: _____
<b>List significant side effects:</b>	
<b>Provider to initial yes or no for each of the following for emergency rescue medications only:</b> (EPI, relief inhalers)	
Is student permitted to carry and self-administer emergency rescue medication? ___ YES ___ NO	
Has student been instructed in self administration of prescribed rescue medication? ___ YES ___ NO	
<b>Date</b>	<b>Physician's Signature</b>
<b>Physician's Name, Address and Phone Number:</b>	

**CMCSS Asthma Emergency Action/Health Plan**  
**School Year 20 \_\_\_\_ - 20 \_\_\_\_**

**Student's Name:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

**Parent/Guardian Input**

Asthma Triggers (please circle): Weather Physical Activity Illness Smoke Pollen Dust Other: \_\_\_\_\_

Known Allergen(s): \_\_\_\_\_


Student has had many or severe asthma attacks/exacerbations: ☐ never ☐ weekly ☐ monthly

Does student take daily asthma medication: ☐ Yes ☐ No List Medication: \_\_\_\_\_

**\*Location of Emergency Medication** ☐ Nurse Clinic ☐ Self-carry (location ex: backpack): \_\_\_\_\_  
☐ Including Spacer

**HEA-F062** Authorization For Medication at school must be completed for **each** medication

**School Nurse to complete below: ALWAYS REFER TO MEDICAL ORDERS**

 **GREEN ZONE** *Child is breathing good, no wheeze/cough, can work and play*

Pretreatment:


☐ Not Required

☐ Administer medication \*see attached authorization

\_\_\_\_\_, Dose: \_\_\_\_\_ puffs  
(name of medication)

☐ PRN: Prior to strenuous activity  
(recess/gym)

☐ Scheduled: Prior to strenuous activity  
(recess/gym)

 **YELLOW ZONE** *Child has some breathing problems, slow to speak, wheeze/cough, problems with work & play*

Administer Quick-relief medication:


☐ Albuterol Dose: \_\_\_\_\_, may repeat after \_\_\_\_\_  
# of puffs (minutes/hours)

☐ Other: \_\_\_\_\_

☐ Nebulizer \*see attached medication authorization

**Do this: \*Call the school nurse**

\*The student should feel better within 20 - 60 minutes of the quick relief medication. If they are getting worse, follow instructions in the RED ZONE.

 **RED ZONE** *Child is breathing hard and fast, ribs pulling in, trouble talking*

**SYMPTOMS OF SEVERE ASTHMA ATTACK**

\*Lips or fingertips turning blue, trouble talking or walking due to shortness of breath, cough constantly, decreased LOC, still in the red zone after 15 minutes, Call 911 and parent/guardian immediately

Administer Quick-relief medication:

☐ Albuterol Dose: \_\_\_\_\_, may repeat after \_\_\_\_\_  
# of puffs (minutes/hours)

☐ Other: \_\_\_\_\_

☐ Nebulizer \*see attached medication authorization

**Do this: \*Call the school nurse**