TORAH SCHOOL OF GREATER WASHINGTON

ASTHMA INHALERS USAGE FORM

*Must be accompanied by the Medication Administration Authorization Form
OR Asthma Action Plan Signed by Parent *and* Health Care Provider

Parents: So that we may provide the best care for your child, please complete this form and return it to the School Nurse. If any changes occur during the year, please notify the nurse.

STUDENT NAME:_____ DATE OF BIRTH: _____

My Child's asthma is triggered by:_____.

Has emergency treatment and or hospitalization been needed in the past? If yes to either, please specify:

_____

My Child takes *maintenance* asthma medication: yes / no (circle one).

_____	_____	_____
Name of Medication	Dose	Frequency of Use

Choose the option you want for your child in school.

❑ Option #1

The student comes to the Health Room where the inhaler is kept, and uses it under supervision. The advantage is that the medication will be used correctly, in the proper amount, and records will be kept.

A number of students keep inhalers in the Health Room and come before PE, recess, or as needed.

- All medications brought to school must be in their original container.
- An adult must bring the medication to school and pick it up at the end of the year.
- The School Nurse will call the prescriber, as allowed by HIPPA, if a question arises about the child and /or the child's medication.

❑ Option #2

QUALIFIED students will be allowed to carry their inhalers. The advantage is that it is immediately accessible. We recommend that a second inhaler be kept in the Health Room should they forget theirs or run out.

CONTRACT BETWEEN STUDENT, PARENTS, SCHOOL NURSE, AND PHYSICIAN TO SELF-CARRY INHALER

1. Student has demonstrated to the School Nurse correct use of the inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees that after two puffs, if there is not marked improvement, he/she will notify a teacher and see the School Nurse immediately.

Student Signature_____ Date _____

I give permission for my child_____to carry the inhaler(s) described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

_____	_____	_____
Name of Medication	Dose	Frequency of Use

Physician Signature _____ Date _____
Print Physician Name_____ Phone _____
Parent Signature _____ Date _____
School Nurse Name and Signature_____ Date _____

Maryland State School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN ____/____/____ (Date) to ____/____/____ (Date) (not to exceed 12 months)

TRIGGER (LIST)

Child's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

Parent/Guardian's Name: _____ Home: _____ Work: _____ Cell: _____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS / INDICATIONS FOR MEDICATION USE

GREEN ZONE

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: _____
- ☐ Peak flow greater than _____ (80% personal best)

CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

EXERCISE ZONE

- ☐ Prior to exercise/sports/ physical education (PE)

Medication (Rescue Medication)	Dose	Route	Frequency/Time

If using more than twice per week for exercise/sports/PE notify the health care provider and parent/guardian.

YELLOW ZONE

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: _____
- ☐ Peak flow between _____ and _____ (50%-79% personal best)

RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

Medication	Dose	Route	Frequency/Time

If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or intercostal retraction
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other: _____
- ☐ Peak flow less than _____ (50% personal best) _____

EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911

Medication	Dose	Route	Frequency/Time

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911.

HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications ◉ Yes ○ No

Health Care Provider Name: _____

Signature: _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child ◉ is ○ is not authorized to self-carry his/her medication(s):

Signature: _____

Date: _____

REVIEWED BY SCHOOL NURSE

Name: _____

Signature: _____

Date: _____

Authorized to self-carry medications: ◉ Yes ○ No