Primary Care Provider Authorization: Asthma (Side One)

Student: ____________________________ Date of Birth: _______________
School: ____________________________ School Year: _______________

Triggers (Check all that apply to this child)
☐ Exercise ☐ Animals ☐ Fumes ☐ Carpet
☐ Strong Odors ☐ Pollen ☐ Molds ☐ Respiratory Infection
☐ Chalk Dust ☐ Change in Temperature ☐ Trees/Grass/Shrubbery
☐ Foods (Specify): ____________________________
☐ Other (Specify): ____________________________

Signs and Symptoms student will likely exhibit (Check all that apply)
*Note: Parent/Guardian will be contacted if symptoms persist
☐ Coughing ☐ Wheezing ☐ Labored/Difficulty Breathing
☐ Other (Specify): ____________________________

Recommended Preventative/Interventive Measures (Check all that apply)
☐ Encourage student to assume position of comfort ☐ Offer warm liquid to drink
☐ Nebulizer (see back of form) ☐ Encourage slow, even breaths
☐ Inhaler name and dosage: ____________________________
☐ Other (Specify): ____________________________

Emergency Plan of Action
* If color becomes pale, cyanotic (blueish), or ashen: Call EMS (9-911)
* If breathing stops: CPR certified staff should initiate rescue breathing (and CPR if necessary)
* Contact parent/guardian or emergency contact immediately
* Other (Specify):

Inhalers
This student has been trained to use his/her inhaler and should be allowed to carry and use their prescribed inhaler on his/her own. ☐ Yes ☐ No

*If yes, please note: Student will be expected to carry and use his/her inhaler responsibly.

Comments: ____________________________________

Please complete both sides if this form
Primary Care Provider Authorization: Asthma (Side Two)

Student: ____________________________ Date of Birth: ____________________________

School: ____________________________ School Year: ____________________________

Nebulizer Inhalation Therapy

Medication via the nebulizer will be given at school as follows:
☐ On a daily basis  ☐ As needed

Medication No. 1 (Name and Dosage):

Medication No. 2 (Name and Dosage):

Time of day to administer:

Reaction or Side effects:

Comments:

Printed Name of MD, ARNP, or PA

Address

Signature of MD, ARNP, or PA

Telephone No.

Date

*Note to parent/guardian: Signing this form shall release the Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.

Signature of Parent/Guardian

Telephone No.

Date

Emergency Contact

Telephone No.

Relationship

Please complete both sides of this form