Elizabethtown Area School District

Asthma/Respiratory Medication Authorization and Action Plan

Student Information

Name of Student: _____ D.O.B.: _____ Grade: _____

In case of an emergency, contact in order:

1. Name:_____ Phone:_____ Phone:_____ Relationship:_____

2. Name:_____ Phone:_____ Phone:_____ Relationship:_____

List triggers:_____

Describe location of the inhaler during the school day (ex: front pocket of backpack):_____

Emergency Action Plan

1. For prevention or treatment of shortness of breath, wheezing, and/or excessive coughing, or prior to exercise.
2. Administration of below prescribed medication(s).
3. Repeat dose at prescribed time.
4. Call parents for pick-up and medical follow-up if symptoms do not improve or resolve in 30 minutes.
5. Call 911 for respiratory emergency
6. Administer Epinephrine Auto-Injector (stock) per standing orders for signs/symptoms of anaphylaxis.

Medication(s) (School)

1. Medication Name:_____ Dose/Route:_____ **puffs** Time: **Q 3-4 hrs./PRN** up to 4x per day

and/or **prior to physical activity** for the duration of the school year. Repeat dose in 20 minutes if symptoms continue.

Possible S/E: jitteriness, _____.

2. Medication Name:_____ Dose/Route:_____ Time:_____ for the duration of the

school year. Repeat dose in _____ minutes if symptoms continue. Possible S/E:_____.

****Inhaler Use:** This student was taught and demonstrates the capability for *self-administration* and for responsible behavior in the use of his/her inhaler. He/she has permission to carry and self-administer his/her inhaler, as prescribed, when needed. *The student shall notify the nurse or designee immediately following each use.* If the student abuses or ignores the school policies, the inhaler may be confiscated and the privilege to carry the medication may be removed.

Provider Initials _____ _____
Yes No

Physician/NP/PA Signature:_____ Print Name:_____
*Signing verifies that the above Emergency Action Plan has been prescribed by you, the child's medical provider, and should be carried out by the school he/she attends.

Phone#:_____ Date:_____

Parent/Guardian Signature:_____ Print Name:_____
**Signing verifies that you, the parent/guardian, give permission for the school staff to carry out the above prescribed plan in your absence and relieve the Board and its employees of responsibility for the benefits or consequences for such medication and its administration.

Phone #:_____ Date:_____