Asthma Action Plan (AAP)

Medication Authorization & Self-Administration Form

in accordance with UCA 53G-9-503

Utah Department of Health/Utah State Office of Education

School Year:

STUDENT INFORMATION

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax or email:
School Nurse:	School Phone:		Fax or email:

History of anaphylaxis where epinephrine was used?

☐ Yes (please also complete anaphylaxis EAP)--allergy to:_____ ☐ No

PHYSICIAN TO COMPLETE

Green Zone: Doing Great!

Student has ALL of these:

- Breathing is easy
- No cough or wheeze
- Can sleep all night
- Able to work and play normally

Controller (preventive) medications **taken at home**:

Medication:_____ Dose:_____ When:_____

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Asthma triggers include: ☐Dust ☐Pet dander ☐Colds ☐Tobacco smoke ☐Mold ☐Exercise ☐Strong odors ☐Pollen ☐Inversions

☐ Other:_____

Take quick-relief medication (see medication order in Yellow Zone):

☐ Before exercise/exposure to a trigger When: _____

☐ Other: _____ When: _____

Yellow Zone: Caution!

Student has ANY of these:

- Coughing or wheezing
- Tight chest
- Shortness of breath
- Waking up at night

Quick-relief medication with spacer (if available):

Medication	Dose	Interval
Inhaler:		
Nebulizer:		
Other:		

Possible side effects:

Parent should contact Healthcare Provider below if 1) quick-relief medication is needed more often than every 4 hours, or needed every 4 hours for more than a day or 2) there is no improvement after taking medication.

Red Zone: Emergency!

Student has ANY of these:

- Can't eat or talk well
- Breathing hard and fast
- Medicine isn't helping
- Rib or neck muscles show when breathing in

Call 911 for an ambulance or go directly to the emergency department

☐ Repeat quick-relief medication every 20 minutes until medical help arrives.

☐ *Other (specify):*

Parent should contact Healthcare Provider below while providing treatment.

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Student Name:	**DOB:**

PRESCRIBER TO COMPLETE

The above named student is under my care. The above reflects my plan of care for the above named student.

☐ **It is** medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times.

☐ **It is not** medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.

Prescriber Name:	Phone:
Prescriber Signature:	Date:

PARENT TO COMPLETE

Parental Responsibilities:

• The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.

• The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.

• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before the designated staff can administer the updated asthma medication prescription.

Parent/Guardian Authorization

☐ **I authorize** my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others.

☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

☐ **I authorize** the appropriate/designated school personnel maintain my child's medication for use in emergency.

Parent Signature:	Date:

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and held harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the asthma action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE (or principal designee if no school nurse)

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication log generated

Inhaler is kept: ☐Student Carries ☐Backpack ☐In Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):

Asthma Action Plan distributed to 'need to know' staff:
☐ Teacher(s) ☐ PE teacher(s) ☐ Transportation ☐ Front Office/Admin ☐Other (specify):

School Nurse Signature:	Date: