# LOWNDES COUNTY SCHOOL DISTRICT

Medication Authorization for Self-Administration

| Student Name: | Date of Birth: |
|---|---|
| School: | Grade: |
| Mother's Name: | Home Phone: Work/Cell: |
| Father's Name: | Home Phone: Work/Cell: |
| Physician's Name: | Telephone: |

_______This student may carry and self-administer the following medications at school.

_______This student may carry the following medication for administration BY school personnel.

Name of medication:_______________________________

Dosage: ___________________Time:_______________

Start Date: _______________End Date: _____________

Symptoms that may indicate need for medication:

_______________________________________________

_______________________________________________

Factors that may trigger/precipitate symptoms:

_______________________________________________

_______________________________________________

Specific instructions if student has symptoms:

_______________________________________________

_______________________________________________

**PHYSICIAN APPROVAL**

I agree with the above medication plan, including the name, purpose, dosage and administration directions of the medication.

It is my professional opinion that this student should be permitted to carry and self-administer this medication.

_______________________________________________

Physicians Signature Date

PARENTAL CONSENT & RESPONSIBILITIES

I, the parent/guardian of the above named child, understand and agree to the conditions of the school policy on medication administration. I permit the school to seek emergency medical treatment for my child when deemed necessary and appropriate. I give authorization for self– administration and possession of the named medication by my child while at school, at school-sponsored activities, while under the supervision of school personnel and while in before-or after-school care on the school property. My child demonstrates a full understanding of the proper use of this medication.

I am responsible for: (1) Monitoring the medication, medication use, and supplying the medication. (2) Ensuring my child always carries this medication on his/her person. (3) Deciding if back-up medication will be kept at school, and providing the school with back-up medication. (4) Informing the school in writing of any changes in treatment or medical condition of my child. (5) Informing the school of any medication side effects of which I should be notified.

I consent for the physician to release information about my child related to this medication to the school nurse.

I release Lowndes County School District its employees of any legal responsibility related to my child's possession and self-administration of this medication.

_______________________________________________

Parent/Guardian Signature Date

STUDENT AGREEMENT: I understand and agree to follow the Lowndes County School District's policy for self-administration of my medication while ate school. I have been instructed in the proper use of this medication. I will be responsible for carrying the medication and will not allow another student to use my medication under any circumstances.

Student Signature_______________________________________ Date_______________

# Asthma Action Plan

**General Information:**

- Name ______
- Emergency contact ______ Phone numbers ______
- Physician/healthcare provider ______ Phone numbers ______
- Physician signature ______ Date ______

**Severity Classification**

❍ Intermittent ❍ Moderate Persistent
❍ Mild Persistent ❍ Severe Persistent

**Triggers**

❍ Colds ❍ Smoke ❍ Weather
❍ Exercise ❍ Dust ❍ Air Pollution
❍ Animals ❍ Food
❍ Other ______

**Exercise**

1. Premedication (how much and when) ______
2. Exercise modifications ______

## Green Zone: Doing Well

**Peak Flow Meter Personal Best =**

**Symptoms**

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

**Peak Flow Meter**

More than 80% of personal best or ______

**Control Medications:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

## Yellow Zone: Getting Worse

**Contact physician if using quick relief more than 2 times per week.**

**Symptoms**

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

**Peak Flow Meter**

Between 50% and 80% of personal best or

______ to ______

**Continue control medicines and add:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN**

❍ Take quick-relief medication every 4 hours for 1 to 2 days.
❍ Change your long-term control medicine by ______
❍ Contact your physician for follow-up care.

**IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN**

❍ Take quick-relief treatment again.
❍ Change your long-term control medicine by ______
❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

## Red Zone: Medical Alert

**Ambulance/Emergency Phone Number:**

**Symptoms**

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

**Peak Flow Meter**

Less than 50% of personal best or

______ to ______

**Continue control medicines and add:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**Go to the hospital or call for an ambulance if:**

❍ Still in the red zone after 15 minutes.
❍ You have not been able to reach your physician/healthcare provider for help.
❍ ______

**Call an ambulance immediately if the following danger signs are present:**

❍ Trouble walking/talking due to shortness of breath.
❍ Lips or fingernails are blue.

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