Asthma Plan/School Medication Order

Name _____ Date of Birth _____Grade _____ Room _____

Physician/Healthcare provider _____Phone Number _____

Physician Signature _____Start Date _____ End Date _____

The following to be completed by physician:

Severity Classification:
□Intermittant □Mild Persistant
□Moderate Persistant
□Severe Persistant

Triggers:
□Colds □Smoke □Weather
□Exercise □Dust □Animals
□Food □Other_____

Exercise:
Premedication _____
Dose _____ When_____

Green Zone: Doing well

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

Control Medications:

Medicine	Dose	When

Yellow Zone: Getting Worse
Some problems breathing
Cough, wheeze or chest tight
Problems working or playing
Wakes up at night time

Contact parents if using quick relief medication more than 2 times a week

Medicine	Dose	When

□ May self-medicate the above medication
□ May repeat in 20 minutes

Red Zone: Medical Alert
Lots of problems breathing
Cannot work or play
Getting worse instead of better
Medication is not helping

Add the following medication

Medicine	Dose	When

Contact parents immediately

Call for an ambulance if: □ Still in the red zone after 15 minutes □ Lips or fingernails are blue

I request that my child be assisted in taking the above medication as prescribed per the asthma action plan above during school hours by an authorized person. My child is permitted to self-medicate themselves as prescribed by the physician, authorized by me or as in accordance with DPH regulations on self-administration of prescription medications (105 CMR 210.06) In event of a field trip delegation will be at the discretion of the nurse. I give my permission for the nurse to discuss with school staff as necessary the information on this form.

_____ _____
Parent/Guardian Signature Date

Home Phone _____Cell Phone_____Emergency Phone_____

_____ _____ _____ _____
School Nurse Signature Date Nurse Signature that verified order Date

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