Utah Department of Health/Utah State Office of Education

Asthma Action Plan, Medication Authorization & Self-Administration Form

in accordance with Utah Code 53A-11-602

______________________	__________	______________________	20 ___ - 20 ___
Student Name	Date of Birth	School	School Year

PHYSICIAN TO COMPLETE:

Green Zone: Doing Great!

If you have 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:__________
Medication:__________________ Dose:__________ When:__________
Medication:__________________ Dose:__________ When:__________

Avoid these asthma triggers: ☐ 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!

If you have ANY of these:

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

Quick-relief medication with spacer (if available):	Dose:	Time interval to repeat dose:
Inhaler:		
Nebulizer:		

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!

If you have 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: ______________________________

Parent should contact Healthcare Provider below while providing treatment.

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

(Please check) ☐ **It is** / ☐ **It is not** medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times. The medication(s) prescribed for this student is/are identified above.

______________	______________	______	______________	______________
Healthcare Provider (print)	Signature	Date	Office Phone	Office Fax

PARENT TO COMPLETE:

(Please check) ☐ **Yes** / ☐ **No** : I authorize my child ______________________________ to carry and self-administer the medications identified above consistent with Utah Code 53A-11-602. My child and I understand there are serious consequences for sharing any medications with others.

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 hold 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. Parents/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 (print)	Signature	Home Number	Cell Number
______________________	______________________	____________	____________
Emergency Contact	Relation	Home Number	Cell Number

SCHOOL NURSE/PRINCIPAL DESIGNEE TO COMPLETE:

☐ Signed by physician and parent (both parts 1 and 2)

☐ Medication is appropriately labeled

☐ Medication log generated

Inhaler is kept: ☐ Student carries ☐ Backpack ☐ In classroom ☐ Health office ☐ Front office ☐ Other:___________

Asthma Action Plan distributed to need-to-know staff:

☐ Teacher(s)

☐ PE teacher(s)

☐ Transportation

______________________________ ____________

Signature Date