

Authorization for Student to Carry and/or Use Asthma Inhaler (for Oregon Schools)

Student's Name: _____
(Last) (First)

Date: _____
(mm/dd/yy)

Acute Asthma Care

Rescue Medication Name: Albuterol Xopenex Other _____

Asthma Attacks:

Common symptoms: *Persistent cough* *Shortness of breath* *Difficulty breathing*

If symptoms occur, student is to take the above rescue medicine.

Dose: Two puffs, one minute between puffs (preferably with spacer).

Repeat in 15 minutes if the student's symptoms do not improve.

Repeat again every three to four hours if symptoms improved, but recur.

- Call parents immediately if student does not respond to the rescue medication.
- Notify the parent, the school nurse and the building administrator of the attack.

For Exercise Induced Asthma:

Student is to take rescue medicine (see above) **prior** to exercise.

The student may take the rescue medication again following exercise, if needed.

Dose: Two puffs 20 minutes prior to exercise.

Two puffs following exercise, if needed.

- Student is capable of carrying and administering his/her inhaler. This student has been instructed in the proper use of these medications.
- Student is capable of carrying but needs assistance using his/her inhaler.
- Student is not to self-carry or self-administer the use of his/her inhaler. He/she requires assistance.

Licensed Health Professional:

I request and authorize that the above-named student take the above identified inhaled medication in accordance with the instructions indicated, as there exists a valid health reason which makes administration of the medication advisable during school hours. This request and authorization is valid for a period of one year from the date listed at the top.

Printed Health Professional Name

Health Professional Signature

Physician/practice contact information

Parent/Guardian:

I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student. I give consent for my child's health care provider and the school to exchange information concerning asthma and severe allergy care.

Parent/Guardian Signature

Date of Signature

Home Asthma Action Plan

(for parents, students who self administer & guardians)

Child's Name: _____ Date: _____
(Last) (First)

Classification of asthma: Intermittent Moderate Persistent
 Mild Persistent Severe Persistent

😊 Asthma is under control

Child has no cough or wheezing, can do daily activities without difficulty, and can sleep through the night without breathing problems.

CONTROLLER MEDICATION— to be taken **every day**. Do not take to school.
This medication should be taken whether your child is or is not having signs of asthma.

_____	_____	am	pm
(Medication name)	(Dose)		
_____	_____	am	pm
(Medication name)	(Dose)		

😞 Asthma with symptoms

If your child gets a cold that might cause asthma to flare up, or your child has symptoms such as:

1. Frequent cough during the day.
2. Sleep disturbed by difficulty breathing or coughing.
3. Difficulty doing daily activities.

Start **RESCUE MEDICATION** **Albuterol** **Xopenex** **Other** _____

Dose: Two puffs, one minute between puffs. (Preferably with spacer)

Repeat in 15 minutes if symptoms do not improve.

Repeat again every three to four hours if symptoms improved, but recur.

Continue **CONTROLLER MEDICATION**—to be taken every day

Extra controller medication does not help with asthma symptoms

⚽ Exercise induced Asthma

- Two puffs of above **RESCUE MEDICATION** 20 minutes prior to exercise.
- Two puffs of same rescue medication following exercise, if needed.

😞 Asthma is not responding to treatment

If your child is short of breath, has constant cough, and **RESCUE MEDICATION** does not help or only helps for a short period of time:

RESCUE MEDICATION— 2-4 puffs or nebulizer treatment **NOW!!!**

Continue **CONTROLLER MEDICATION**—to be taken every day

Call your Doctor

Use Oral steroid _____
(Medication name) (Dose) (How often)

👉 **Call 911** if your child is using neck muscles to breath, has trouble walking or talking, has gray or blue lips or fingernails, or is becoming unresponsive.