
Primary Care Provider Authorization: Asthma (Side One)

Student: _____ Date of Birth: _____
School: _____ School Year: _____

Triggers (Check all that apply to this child)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Animals | <input type="checkbox"/> Fumes | <input type="checkbox"/> Carpet |
| <input type="checkbox"/> Strong Odors | <input type="checkbox"/> Pollen | <input type="checkbox"/> Molds | <input type="checkbox"/> Respiratory Infection |
| <input type="checkbox"/> Chalk Dust | <input type="checkbox"/> Change in Temperature | <input type="checkbox"/> Trees/Grass/Shrubbery | |
| <input type="checkbox"/> Foods (Specify): _____ | | | |
| <input type="checkbox"/> Other (Specify): _____ | | | |
-

Signs and Symptoms student will likely exhibit (Check all that apply)

***Note: Parent/Guardian will be contacted if symptoms persist**

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Labored/Difficulty Breathing |
| <input type="checkbox"/> Other (Specify): _____ | | |
-

Recommended Preventative/Interventive Measures (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Encourage student to assume position of comfort | <input type="checkbox"/> Offer warm liquid to drink |
| <input type="checkbox"/> Nebulizer (see back of form) | <input type="checkbox"/> Encourage slow, even breaths |
| <input type="checkbox"/> Inhaler name and dosage: _____ | |
| <input type="checkbox"/> Other (Specify): _____ | |
-

Emergency Plan of Action

- * If color becomes pale, cyanotic (bluish), or ashen: Call EMS (9-911)
 - * If breathing stops: CPR certified staff should initiate rescue breathing (and CPR if necessary)
 - * Contact parent/guardian or emergency contact immediately
 - * Other (Specify): _____
-

Inhalers

This student has been trained to use his/her inhaler and should be allowed to carry and use their prescribed inhaler on his/her own. Yes* No

***It yes, please note: Student will be expected to carry and use his/her inhaler responsibly.**

Comments: _____

Please complete both sides if this form

Primary Care Provider Authorization: Asthma (Side Two)

Student: _____ Date of Birth: _____
School: _____ School Year: _____

Nebulizer Inhalation Therapy

Medication via the nebulizer will be given at school as follows:

On a daily basis As needed

Medication No. 1 (Name and Dosage): _____

Medication No. 2 (Name and Dosage): _____

Time of day to administer: _____

Reaction or Side effects: _____

Comments: _____

Printed Name of MD, ARNP, or PA _____ Address _____

Signature of MD, ARNP, or PA _____ Telephone No. _____ Date _____

***Note to parent/guardian: Signing this form shall release _____ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

Signature of Parent/Guardian _____ Telephone No. _____ Date _____

Emergency Contact _____ Telephone No. _____ Relationship _____

Please complete both sides of this form
