

Primary Care Provider Authorization: Asthma or Restrictive Airway Disease

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

Triggers (Check all that apply to this child)

- Exercise Animals Fumes Carpet
 Strong Odors Pollen Molds Respiratory Infection
 Chalk Dust Change in Temperature Trees/Grass/Shrubbery
 Foods (Specify): _____
 Other (Specify): _____

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

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

- Coughing Wheezing Labored/Difficulty Breathing
 Other (Specify): _____

Recommended Preventative/Interventive Measures (Check all that apply)

- Encourage student to assume position of comfort Offer warm liquid to drink
 Nebulizer (see back of form) Encourage slow, even breaths
 Inhaler name and dosage: _____
 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

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

Comments: _____

Please complete both sides if this form

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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
