Alief Independent School District
Kleinzman Intermediate School
Parental Consent to Administer Medication at School

Student _____ Grade___ DOB_____ Teacher_____

Medication_____ Dosage_____

Time to be given _____ Dates to be given_____

Reason student is receiving medication_____

I would like school personnel to give the above medication as directed.

If medication is to be given more than 10 consecutive days,
Doctor will have to authorize administration.

Parent/Guardian Signature _____ Date_____

Home phone ( ) _____ Daytime phone ( )_____

ALIEF INDEPENDENT SCHOOL DISTRICT

PHYSICIAN'S REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

Name of student _____ DOB _____

Condition for which medication is required _____

Medication _____

Dosage and method of administration _____

Special instructions _____

Physicians' name (please print) _____

Physician's phone _____ Fax _____

Physician's signature _____ Date _____

Parent's signature _____ Date _____

AISD 45-0430 REV 9/98

ASTHMA ACTION PLAN

This form must be completed at the beginning of each school year

StudentName:_____DOB:_____Gr./Teacher:_____
Mother/Guardian_____ Emergency contact number_____
Father/Guardian_____Emergency contact number_____

Physician Name _____Phone_____ FAX_____

♦ACTION FOR MILD WHEEZING♦

1. Medication:_____
   Dose_____
   Frequency_____

Can be repeated for severe breathing difficulty _____times_____minutes apart.

♦ACTION FOR SEVERE WHEEZING♦

1. Medication:_____
   Dose_____
   Frequency_____

Can be repeated for severe breathing difficulty _____times_____minutes apart.

Call 911 if minimal or no improvement

Seek emergency care if this student experiences any of the following:
No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.

Student exhibits:

Retractions
Stops playing and cannot start activities again
Trouble walking or talking

_____
_____

Shortness of breath
Hunched over while breathing
Lips or fingernails turn blue or gray

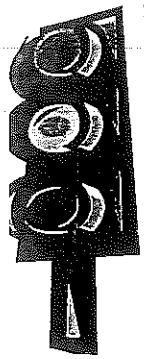
_____
_____

☐ This child has been instructed in the proper administration of medication. It is my professional opinion that he/she should be allowed to carry and self-administer the above medication while on school property or at school related events

☐ It is my professional opinion that he/she should **NOT** be allowed to carry and self-administer the above medication while on school property or at school related events. The medication should be kept locked in the school clinic.

Parent's signature_____Date_____

Doctor's signature_____Date_____



The colors of a traffic light will help you use your asthma medicines.

Green = Go Zone!
Use preventive medicine.

Yellow = Caution Zone!
Add quick-relief medicine.

Red = Danger Zone!
Get help from a doctor.

PREDICTED NORMAL PEAK FLOW READING:

_____ *lpm*

CENTRAL TEXAS ASTHMA ACTION PLAN

To be completed by Physician Designee and signed by Physician

Date _____

Patient Name _____

Date of Birth _____

Has the patient ever been admitted to ICU? ( ) Yes ( ) No
Has the patient ever required mechanical ventilation? ( ) Yes ( ) No

Grade in School _____

Please classify this patient's asthma. *Refer to these choices adopted from the NIH Asthma Management Guidelines.*
Asthma Classification by Physician: **( ) Mild intermittent** **( ) Moderate persistent** **( ) Mild persistent** **( ) Severe persistent**

Classification	Days with symptoms	Nights with symptoms	FEV1 or PEF (% pred. normal)
Severe persistent	Continual	Frequent	≤ 60%
Moderate persistent	Daily	≥ 5/month	> 60% to <80%
Mild persistent	> 2/week	3 to 4/month	≥ 80%
Mild intermittent	≤ 2/week	≤ 2/month	≥ 80%

GREEN ZONE: *No signs or PF 80-100% of Predicted Normal or Personal Best – Take Preventative Medication*

PEAK FLOW FROM _____ TO _____

You have all of these

- Breathing is good
- No cough or wheeze
- Sleep through night
- Can work and play

1. What preventative medications are prescribed and how often are they given? Name and Dose:

_____

2. Does this patient have Exercised Induced Asthma? ( ) Yes ( ) No If yes, what medication should be given for EIA?
Take only one of the treatments 15-20 minutes before physical activity as needed.
❑ ALBUTEROL 2 puffs MDI & chamber ❑ ALBUTEROL 1 vial in nebulizer

❑ XOPENEX 2 puffs MDI & chamber ❑ XOPENEX 1 vial in nebulizer

❑ OTHER: _____

YELLOW ZONE: *Caution Signs or PF 50 – 79% of Predicted Normal or Personal Best – Continue Preventative Medication*

PEAK FLOW FROM _____ TO _____

You have *any* of these:

- First signs of a cold
- Exposure to known trigger
- Coughing doesn't stop
- Mild wheeze
- Chest tightness

In case of an asthma exacerbation, what quick-relief medication should be used?
Take one treatment every 4-6 hours as needed for 24-48 hours.
Recheck peak flow 15 minutes after treatment
❑ ALBUTEROL _____ puffs MDI & chamber ❑ ALBUTEROL 1 vial in nebulizer

❑ XOPENEX _____ puffs MDI & chamber ❑ XOPENEX 1 vial in nebulizer

❑ OTHER: _____

If treatments are needed for longer than 24-48 hours, call your doctor.

RED ZONE: *Danger Signs or PF Below 50% of Predicted Normal or Personal Best – Continue Preventative Medication*

PEAK FLOW BELOW _____

Your asthma is getting worse fast:

- Medicine isn't helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show during breathing
- Can't talk well.
- **Inhale & exhale wheeze**

1. In case of an asthma exacerbation, what quick-relief medication should be used?
Take one treatment every 20 minutes for up to three treatments only.
Recheck peak flow 15 minutes after treatment
❑ ALBUTEROL _____ puffs MDI & chamber ❑ALBUTEROL 1 vial in nebulizer

❑ XOPENEX _____ puffs MDI & chamber ❑XOPENEX 1 vial in nebulizer

❑ OTHER: _____

2. Get **immediate** medical attention – Call your doctor. If at school, go to the nurse. Or, call 911.

Physician signature: _____ Physician name: _____ Telephone(___)_____ Date:_____

For children in school: ***School Name:*** _____ ***School district:*** _____

I, the above signed physician, certify that the above named student has asthma and is capable of carrying and self-administering the above quick-relief asthma medication. (Texas Inhaler Law.) **( ) Yes ( ) No**

I give permission for the school nurse to administer the above physician orders and to communicate with my child's health care provider concerning my child's asthma.

Parent signature: _____ Parent name: _____ Telephone: (___)_____ Date:_____