

Centerville City Schools  
**AUTHORIZATION FOR ADMINISTRATION OF INHALED ASTHMA MEDICATION**  
*(In accordance with ORC 3313.716/33/3.14 and Sub S.B. No. 164)*

**Parent Section**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade/ Teacher: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Home

*As the Parent / Guardian of this student: **I authorize**      **Do not authorize** (circle one) my child to possess and self administer the inhaled asthma medication as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. If self administration is not authorized, the administration of this prescribed medication may be administered by trained school staff. I have read and understand Centerville City Schools Medication Policy. **I give permission for this information to be sent to the school via facsimile.***

Emergency contacts: name/relationship	Phone number (s)
1. _____	1. _____ 2. _____
2. _____	1. _____ 2. _____
3. _____	1. _____ 2. _____

Parent/Guardian name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian signature: \_\_\_\_\_ Phone \_\_\_\_\_  
Work/cell

**ASTHMA ACTION PLAN**

What triggers your child's asthma attack (**check all that apply**):

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Illness   | <input type="checkbox"/> Cigarette or other smoke   | <input type="checkbox"/> Food _____  |
| <input type="checkbox"/> Strong emotions   | <input type="checkbox"/> Exercise   | <input type="checkbox"/> Stress      |
| <input type="checkbox"/> Change in temperature   | <input type="checkbox"/> Indoor/outdoor pollution, odors                                    | <input type="checkbox"/> Chalk dust  |
| <input type="checkbox"/> Allergies <input type="checkbox"/> cat <input type="checkbox"/> dog | <input type="checkbox"/> dust <input type="checkbox"/> mold <input type="checkbox"/> pollen | <input type="checkbox"/> Other _____ |

**Control of School Environment:** List environmental control measures, pre-medications, and/or dietary restrictions the student needs to prevent an asthma episode: \_\_\_\_\_

Describe the symptoms your child experiences before or during an asthma episode (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cough, persistent                          | <input type="checkbox"/> "Tightness" or pain in chest | <input type="checkbox"/> Rubs/scratches chin/neck        |
| <input type="checkbox"/> Wheezing                                   | <input type="checkbox"/> Irritability or agitation    | <input type="checkbox"/> complains of feeling tired/weak |
| <input type="checkbox"/> Shortness of breath or breathing hard/fast | <input type="checkbox"/> Runny nose                   | <input type="checkbox"/> Other _____                     |

**Peak Flow Monitoring:** Personal Best Peak Flow Number

Green Zone: \_\_\_\_\_ Yellow Zone: \_\_\_\_\_ Red Zone: \_\_\_\_\_

**CALL 911 FOR:**

- Rapid, labored breathing
- Pulling of skin of neck and chest with breathing and nasal flaring
- Can talk only in short, clipped sentences
- Blueness around mouth and nailbeds (paleness in children of color)
- Change in mental status (becoming agitated, anxious, declining consciousness)
- Sweaty, clammy skin

**Home Medication** (given daily and/or as needed):

Medication Name	Dose	When to Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**School Medications:      \*\* MUST HAVE MEDICATION AUTHORIZATION FORM ON BACK COMPLETED BY PHISICIAN\*\***

Medication Name	Dose	When to Use
1. _____	_____	_____
2. _____	_____	_____

## ASTHMA MEDICATION ORDERS

*To be completed by Physician*

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_  
(one medicine per form)

**Dose:** \_\_\_\_\_ **Times to be given:** \_\_\_\_\_

Date administration is to begin: \_\_\_\_\_ to end: \_\_\_\_\_

Medication is to be administered for the following signs/symptoms: \_\_\_\_\_  
\_\_\_\_\_

If needed, how soon can medicine be repeated: \_\_\_\_\_

The medication cannot be repeated more than: \_\_\_\_\_

What procedure(s) should school personnel follow in the event that the inhaled asthma medication does not produce expected relief from the student's asthma attack: \_\_\_\_\_  
\_\_\_\_\_

**Adverse reactions that should be reported to physician:**

- For the student for which it **is prescribed**: \_\_\_\_\_  
\_\_\_\_\_

- For the student for which it is **not prescribed** who receives a dose: \_\_\_\_\_  
\_\_\_\_\_

Special instructions: \_\_\_\_\_

\_\_\_\_\_ As the prescriber, I have determined that this student **is capable** of possessing and self administering this inhaled asthma medication appropriately and have provided the student with training in the proper use of the inhaler. (Please consider providing a backup inhaler for the school clinic.)

\_\_\_\_\_ As the prescriber, I have determined that this student **is not capable** of possessing and using this inhaled asthma medication appropriately and administration of this medication should be administered by trained school personnel.

Physician Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_ Emergency number: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_