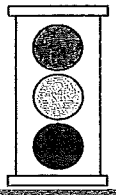
Name: _____

DOB (mm/dd/yyyy): _____

School: _____



ASTHMA MEDICINE PLAN

You can use the colors of a traffic light to help learn about your asthma medicines:

1. GREEN means GO. Use your everyday preventive medicines
2. YELLOW means CAUTION. Use quick-relief medicine.
3. RED means DANGER! Use extra medicines and call your doctor NOW!

GREEN means GO!!! — USE PREVENTION MEDICINES EVERY DAY

*** Breathing is good**
*** No cough or wheeze**
*** Can work and play**

☐ Not Applicable (no prevention medicines)

Medicine	How Much to Take	Times to Take	Take at School?
			☐
			☐
			☐

20 minutes before exercise use this medicine: _____

YELLOW means CAUTION!!! — START TAKING QUICK RELIEF MEDICINE

Cough

Wheeze

Tight Chest

Wake up at Night

1. KEEP TAKING GREEN ZONE MEDICINES
2. TAKE QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD

Medicine	How Much to Take	Times to Take

*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN
**IF SYMPTOMS CONTINUE FOR 12 TO 24 HOURS, CALL YOUR DOCTOR

RED means DANGER!!! — GET HELP FROM A DOCTOR NOW!!!

*** Medicine is not helping**
*** Breathing is hard and fast**
*** Nose opens wide to breathe**
*** Can't talk well**

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How Much to Take

May repeat _____ times, 20 min. apart

CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Physician recommendations for Air Quality Alert Days: (Check one)

○ No outdoor exercise ○ Limited outdoor activity (no sprints, running, etc.) ○ Exercise as tolerated

Other: _____

Physician recommendations for medication self-administration: (Check one)

○ The student above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school related events.

○ The student above, in my professional opinion, should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events.

Printed Name of Health Care Provider	Signature of Health Care Provider	Phone Number	Date

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child's physician to share written or verbal information with the school nurse for the duration of this school year.

_____ _____
Signature of parent/guardian Date

_____ _____ _____
Home Telephone Work Telephone Cell Phone

SOUTH TEXAS ASTHMA COALITION

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio

Contact the author, Dr. Steve Inscore Inscore@sbcglobal.net for information about modifications.

CFISD

Permission to Self-Transport/Administer Medication

Student Name: _____ ID#: _____ Grade: _____

With parent permission, a statement of the student's ability to self-transport/administer his/her medication from the prescribing medical provider, and a school nurse's evaluation, students in CFISD may self-transport/administer certain emergency medications. The medication must be transported in the **original container**, and the student should only carry a **daily dose of the medication**. The student is responsible to maintain his/her medication in an appropriate and accessible place at all times. The transport/use of undisclosed medications may result in disciplinary action according to the student code of conduct.

I, _____ [parent/guardian name], give permission to my son/daughter to transport and self-administer the medication(s) listed below while on a school campus. My child has demonstrated his/her understanding of proper medication use and understands that the medications listed below are not to be shared with others or taken in any way other than directed by the prescribing physician or manufacturer. I also understand that the misuse of medications can result in disciplinary action for my child according to the student code of conduct. On this form, I have disclosed all medications that my child is permitted to carry.

Parent Signature: _____ Date: _____/_____/20_____

I, _____ [student name], understand proper medication use and that the medication(s) listed below is only for my use during the school day. I will be responsible with my medication(s), take it only as directed by the prescribing physician or manufacturer, store them in a safe place in my belongings, and I will not share them with others under any circumstance. I also understand that the misuse or sharing of my medications can result in disciplinary action according to the student code of conduct. I will seek assistance from the school nurse or a responsible adult if I must administer an emergency medication(s) while at any CFISD school.

Student Signature: _____ Date: _____/_____/20_____

Medication 1: _____ Dose: _____ Route: _____
Reason for use: _____ Expiration date: _____/_____/20_____

Medication 2: _____ Dose: _____ Route: _____
Reason for use: _____ Expiration date: _____/_____/20_____

Medication 3: _____ Dose: _____ Route: _____
Reason for use: _____ Expiration date: _____/_____/20_____

For school nurse use only

I certify that the student named above:

Knows the name and purpose of the medication(s) he/she will self-transport	Yes / No
Knows the prescribed medication dose	Yes / No
Articulates the appropriate time and circumstance under which the medication(s) should be administered	Yes / No
Demonstrates the correct administration of the medication(s) listed above	Yes / No
Understands the period for which the medication(s) is/are prescribed	Yes / No

School Nurse Signature: _____ Date: _____/_____/20_____