School Supplementary Treatment Orders

(To be Sent with the Asthma Action Plan)

Student Name: **Birthdate:**

Asthma Rescue Medications:

See attached **Asthma Action Plan**:

Please follow the treatment plan detailed in the Green zone for activity/exercise treatment and rescue medication plan for Green, Yellow & Red zones, according to asthma symptoms.

Common side effects of albuterol/levalbuterol include increased heart and respiratory rate and jitteriness.

☐ The student may carry and self-administer their inhalers

Pre-activity treatment, including before physical education/recess, should be given:

☐ With all activity ☐ Only when the child or school staff feels he/she needs it

If a Student is in the Red Zone, immediately give their rescue treatment and call 911.
Please follow school emergency plans, according to school/school system policy.

Controller Medications:

Only the following controller or steroid medications should be administered in school:

	AM Dose	PM Dose

If not listed on the Asthma Action Plan:

Triggers:

School specific triggers include: _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

Please Contact the Asthma Provider listed here with any questions or concerns regarding these orders, or if the student does not have adequate/correct medications in the school.

Asthma Provider Printed Name & Contact Information:

Asthma Provider Signature: Date:

Parent/Guardian Permission: I give permission for the medications listed in the Asthma Action Plan to be administered in the school by the nurse or other school members in accordance with school policy. I consent to sharing health information between the prescribing health care provider/clinic, the school nurse, and the school medical advisor necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:

For School Use: ☐ School nurse agrees with student self-administering the inhalers

School nurse received/Signature: Date:

Please send a signed copy back to the provider at the contact listed above.