

# St. Charles Borromeo School

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## PHYSICIAN'S ORDER & MEDICATION AUTORIZATION FORM Asthma Medication Form

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The following is to be completed by the Health Care Provider:

Diagnosis of student: (circle one of the following :) Mild Intermittent Asthma  
Mild Persistent Asthma Moderate Persistent Asthma Severe Persistent Asthma

Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time of Administration: \_\_\_\_\_

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

Do you want this medication taken before physical education class? Yes/No

Does the student use a peak flow meter? Yes/No Student personal best: \_\_\_\_\_

Student's Asthma Triggers: \_\_\_\_\_

**Please fill out all three zones of action plan below.**

### Green Zone

Doing Well: No cough or wheeze, sleeping through the night without symptoms, can go to school and play. Peak flow is 80-100% of personal best or \_\_\_\_\_.  
Daily medication as usual noted by above physician orders.

### Yellow Zone

Any of the following symptoms: first sign of a cold, cough, mild wheeze, tight chest, coughing, wheezing at night or trouble breathing at night. Peak Flow is 50-80% of personal best or \_\_\_\_\_.  
Take the following action: \_\_\_\_\_.  
Contact parent is no improvement.

### Red Zone

Asthma is worse: medicine is not working, breathing is hard and fast, and nose flares open to breath, ribs show during inspiration. Student is having difficulty with talking. Peak Flow is less than 50% of personal best or \_\_\_\_\_.  
Take the following action: \_\_\_\_\_.  
Contact physician at \_\_\_\_\_ Call parent at \_\_\_\_\_.  
If no improvement activate 911.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### PARENT/GUARDIAN STATEMENT:

I/We, the undersigned parent(s)/guardian(s) of \_\_\_\_\_, Request that a school employee assist the student with the self administration of the above medication, according to the physician's instructions. I/We agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement of medication when necessary, and I/We agree to notify the school immediately if the physician or medication prescription is changed.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_