Murrieta Valley Unified **MEDICATION AUTHORIZATION/ASTHMA ACTION PLAN** Health Services

Student Name	Date of Birth	School
Parent Name	Phone	Teacher/Grade

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

Asthma Triggers: ☐ Exercise ☐ Pollens ☐ Illness ☐ Weather ☐ Animals ☐ Other _____
☐ Odors ☐ Dust ☐ Colds ☐ Smoke ☐ Mold/Moisture ☐ Stress/Emotions

GREEN ZONE: DOING WELL GO!

Student has ALL of these:

- Breathing is easy
- No cough or Wheeze
- Can work and play
- Can sleep all night

-OR-

Peak Flow is Between ____ and ____
(80-100% of personal best)

☐ No control Medications Required

-OR-

_____
Medication How Much When

_____
Medication How Much When

☐ Before Exercise

_____ , _____ puff (s) **5 minutes before exercise**
Medication

YELLOW ZONE: GETTING WORSE CAUTION!

Student has ANY of these:

- Hard to breathe
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

-OR-

Peak Flow is Between ____ and ____
(50-79% of personal best)

☐ _____ , _____ puff (s) every _____ hours as needed
Medication

-OR-

☐ _____ , _____ vial via nebulizer every _____ minutes as needed
Medication

☐ Other _____

If you are in the Yellow Zone for more than 6 hours, or your symptoms are getting worse, Follow RED ZONE instructions.

RED ZONE: EMERGENCY GET HELP NOW!

Student has ANY of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and/or fingernails
- Tired or Lethargic
- Ribs show or Nostrils flare

-OR-

Peak Flow is Between ____ and ____
(Less than 50% of personal best)

☐ _____ , _____ puff (s) every _____ minutes as needed
Medication

-OR-

☐ _____ , _____ vial via nebulizer every _____ minutes as needed
Medication

☐ Other _____

Call your health care provider <u>now</u> AND go to the emergency room
OR CALL 911 IMMEDIATELY

Possible side effects of quick relief medications (e.g. Albuterol) include tachycardia, tremors, and nervousness.

☐ Student is capable and approved to self-administer the medication(s) named above. He/she has demonstrated knowledge of the correct dosage and administration and is sufficiently responsible to carry out my directions as instructed.

☐ Student is **<u>NOT</u>** approved to carry and self-administer the medication(s) named above.

_____ _____
Physician Name/Signature Date/Contact Information

I hereby authorize for the above health care provider's disclosure of health information to the district. I authorize trained school employees, if available, to administer medication to my student and agree to hold MVUSD and its employees harmless from all liability or claims that may arise out of these arrangements. The school is authorized to secure emergency medical services for my child whenever the need for such services are deemed necessary by the principal, school nurse, or designated school staff member. I understand that all medication will be destroyed at the end of the school year unless other arrangements are made.

☐Yes ☐No My child may carry and self-administer quick relief medication at school **(MD approval required). The principal or designee reserves the right to revoke the privilege if the student demonstrates irresponsible behavior or incorrect administration.**

_____ _____
Parent/Legal Guardian Date