Asthma Management Authorization Form

Child's Name	Date of Birth	Effective Date
School	School Contact	School Number
Doctor	Parent/Guardian	Emergency Contact
Phone	Phone	Phone
Self Administer APPROVED NOT APPROVED	Triggers	

	MEDICATION	STRENGTH	DOSE	HOW OFTEN
GREEN ZONE Daily Medicines Medicines to Keep Asthma Controlled				
	Albuterol MDI with spacer Levalbuterol MDI with spacer		2 puffs	Before Sports Before Bed
YELLOW ZONE Exacerbation Medicines Medicines to regain control Start if you have: Cough, Mild Wheeze, Tight Chest Coughing at Night, Coughing Fits **And Call your Doctor**	Albuterol MDI with spacer		2 puffs	Every 4 hrs as needed
	Albuterol Nebulizer Solution	1.25 mg 2.5 mg	1 vial by nebulizer	Every 4 hrs as needed
	Levalbuterol MDI with spacer		2 puffs	Every 4 hrs as needed
	Levalbuterol Neb Solution	0.31 mg 0.63 mg 1.25 mg	1 vial by nebulizer	Every 4 hrs as needed
RED ZONE Emergency **CALL 911** Use if you have no relief with YELLOW ZONE Medications in 15-20 min, Breathing is hard, Trouble Talking, Lips or Fingernails Blue	Albuterol MDI with spacer		2 puffs	Every 20 minutes
	Albuterol Nebulizer Solution	1.25 mg 2.5 mg	1 vial by nebulizer	Every 20 minutes
	Levalbuterol MDI with spacer		2 puffs	Every 20 minutes
	Levalbuterol Neb Solution	0.31 mg 0.63 mg 1.25 mg	1 vial by nebulizer	Every 20 minutes

This information establishes my child's asthma treatment plan as directed by his or her provider. I hereby give permission for my child to receive medication at school as prescribed in the treatment plan. I also give permission for the release and exchange of information between the school nurse and my child's health provider concerning my child's health and medications on a need to know basis.

Parent's Signature : _____ Date: _____

Physician/APN/PA Signature:_____ Physician phone :_____

Physician/APN/PA Name:_____ Physician Fax : _____

Remarks: _____

School Nurse: _____ Phone: _____ Fax: _____