

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:

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:

<u>For School Use</u>: School nurse agrees with student self-administering the inhalers School nurse received/Signature:

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

Page _____ of ____

Date:

Date:

Date: