CAPE FEAR VALLEY
PEDIATRIC ASTHMA PROGRAM

Cumberland County Schools
Asthma Medication Plan

Rev. 9/14

ASTHMA MEDICATION PLAN *(to be completed by the Student's Medical Provider)*

Name of School: _____

Name of Student: _____ Grade: _____ Age: _____

The above named person is a patient currently under my medical care. Due to a medical diagnosis of asthma, the medication listed below needs to be given during the regular school day according to the following protocol:

List Rescue Medication Name or Albuterol on line below:

_____

Medication dose ranges are not allowed at school. Please indicate a specific number of puffs to be given.

☐ **PRETREATMENT BEFORE EXERCISE**
Give # _____ Puffs of Rescue Medication or Albuterol 5-15 minutes prior to PE, sports or strenuous exercise.

ASTHMA TRIGGERS

☐ Colds ☐ Perfume/Cologne
☐ Dust ☐ Strong Smells
☐ Grass ☐ Weather Changes
☐ Pollen ☐ Other: _____

YELLOW ZONE – COUGHING, WHEEZING AND DIFFICULTY BREATHING!

1ST → For asthma symptoms at school, give Rescue Medication or Albuterol
☐ MDI #_____ puffs OR ☐ Nebulize #_____ vial of _____ mg/3mL
Directions: Give every 4-6 hours as needed

2ND → If student continues to have symptoms, or condition worsens, call student's parent/guardian to notify use of medication & report symptoms, then begin RED ZONE DIRECTIONS NOW.

Yellow Zone Peak Flow Range: _____ to _____ *(Optional)*

RED ZONE – BREATHING IS HARD & FAST, HARD TO TALK OR WALK!

1ST → This is an Emergency, give Rescue Medication or Albuterol IMMEDIATELY
☐ MDI #_____ puffs OR ☐ Nebulize #_____ vial of _____ mg/3mL
Directions: Give every 20 minutes for up to 1 hour

2ND → **Call 9-1-1** if no improvement after first Red Zone dose of medication!
Call parent/guardian or emergency contact for student pick up.

Physician's Signature: _____ Date: _____

Clinic Address: _____ Phone: _____

RELEASE OF LIABILITY FORM *(to be completed by the Student's Parent/Guardian)*

I, _____, the parent and/or legal guardian of

(Name of Child) _____ enrolled at (Name of School) _____

Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing for the term of one year.

Parent or Guardian Signature: _____ Date: _____

Principal Signature: _____ Date: _____

FOR SCHOOL USE ONLY

Date Asthma School Medication Form Expires: _____ / _____ / _____

Please be reminded form will expire one (1) year from date of physician's signature.