Davison Community Schools
1490 N. Oak Rd. Davison, MI 48423
Phone (810) 591-0913 Fax (810) 591-2674

Authorization to Administer Medication

Student Name _____ **School** _____

Teacher _____ **Room Number** _____ **Grade** _____

Physician's Order **(Must be completed by physician or designee)**

Name of medication _____ Reason for medication _____

Dose _____ Time to be Given _____

For episodic/emergency use only ___ yes ___ no

Route to be given (please check)
___ by mouth (___ capsule ___ tablet ___ liquid)
___ injection
___ inhaler/nebulizer
___ drops
___ other _____

Side effects to observe: ___ none anticipated ___ yes, describe _____

Special storage considerations: ___ none ___ refrigerate

Start date _____ Stop date _____ End of school year _____

Self-Administration

This student is both capable and responsible for carrying and self-administering this medication. ___ Yes ___ No

Physician Name _____ Phone Number _____

Address _____

Physician Signature _____ Date _____

Parent/Guardian Authorization to Administer Medication **(Must be completed by parent or guardian)**

I have read the school's policy and procedures pertaining to administration of medication. I agree to follow the procedures and request that (student's name) _____

_____ Receive the medication specified above at school according to school policy and procedure.

_____ Request that my child be allowed to self-administer the medication specified above according to school policy and procedure. (***Can only be requested with physician's written approval above.)***
(Note: School policy does not allow students to self administer controlled substances.)

Parent/Guardian Signature _____ Date _____

Home phone _____ Cell phone _____ Work phone _____

Office Use Only

Date received _____ *Number of pills received* _____ *Date medication returned to parent* _____

Please Fill Out Both Sides!

Asthma Action Plan

Name	Date of Birth	Effective Date / / to / /
Doctor		Parent/Guardian
Doctor's Office Phone Number: Day		Parent's Phone
Emergency Contact After Parent		Contact Phone
Student is able to self medicate ☐ Yes ☐ No		

The colors of a traffic light will help you use your asthma medicines. Also pay attention to symptoms

Green means GO ZONE
Use preventive medicine

Yellow means CAUTION ZONE! Add prescribed yellow zone medicine

Red means DANGER ZONE! Get help from a doctor

GO (GREEN) — Use these medicines every day.

You have *ALL* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work or play

Peak flow above _____

Medicine	How Much to Take	When to Take It

For asthma with exercise, take:

CAUTION (YELLOW) — Continue with green zone medicine and ADD:

You have *ANY* of these:

- First sign of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

And/or Peak flow from _____ to _____

Medicine	How Much to Take	When to Take It
First →		
Next →		

→ **IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK, THEN CALL YOUR DOCTOR.**

DANGER (RED) — Take these medicines and call your doctor.

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips and/or fingernails blue
- Trouble walking and talking

And/or Peak flow below _____

Medicine	How Much to Take	When to Take It

Get help from a doctor now! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It is IMPORTANT! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Asthma Triggers

Check all items that trigger your asthma and things that could make your asthma worse:

- ☐ Chalk dust
- ☐ Cigarette Smoke and second hand smoke
- ☐ Colds/Flu
- ☐ Dust mites, dust, stuffed animals, carpet
- ☐ Exercise
- ☐ Sudden temperature change
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests-rodents and cockroaches
- ☐ Pets-animal dander
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfumes, cleaning products
- ☐ Wood Smoke
- ☐ Foods _____
- ☐ Other _____

Doctor's Signature/Stamp

AIM Asthma Initiative of Michigan
FOR HEALTHY LUNGS
www.GetAsthmaHelp.org

Adapted from the original design by the Pediatric Asthma Coalition of New Jersey

Please Fill Out Both Sides!