



**Rio Rancho Public Schools  
Safe Schools After School Program  
Asthma Medication Form  
One form per medication**

Student Name _____	Date _____
Grade _____	DOB _____

The following is to be completed by a Health Care Provider

Diagnosis of Student (Please circle one of the following):

ICD-9 code \_\_\_\_\_

Mild Intermittent Asthma    Mild Persistent Asthma    Moderate Persistent Asthma    Severe persistent Asthma

Other \_\_\_\_\_

Allergies \_\_\_\_\_

Student Asthma Triggers \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_ Time \_\_\_\_\_

Special Instructions \_\_\_\_\_

Do you want this medication taken before Physical Activity? YES NO

Student may carry his/her own MDI? YES NO.

Does the student use a Peak Flow Meter? YES NO    What is her/his personal best value? \_\_\_\_\_

**\*\* RRPS employees encourage the use of spacers for all Metered Dose Inhalers. \*\***

Please fill out all three zones of the action plan below.

<p><b>Green Zone</b> Doing Well: No cough or wheeze, sleeping through the night without symptoms, can go to school and play. Peak Flow is 80-100% of personal best. _____ <b>Daily Medication as usual (see above orders)</b></p>
<p><b>Yellow Zone</b> Any of the following symptoms: first sign of a cold, cough, mild wheeze, tight chest, coughing, wheezing at night or trouble breathing at night. Peak flow is 50-80% of personal best or _____ <b>Take the following action</b> _____ <b>Contact parent if no improvement.</b></p>
<p><b>Red Zone</b> Asthma is worse: medicine is not working, breathing is hard and fast, nose flares open to breathe, ribs show during inspiration. Student is having difficulty with talking. Peak flow is less than 50% of personal best or _____ <b>Take the following action</b> _____ <b>Contact Parent</b> _____ <b>Contact physician</b> _____ <b>If no improvement activate 911.</b></p>

Physician signature \_\_\_\_\_ Phone \_\_\_\_\_

Physician's printed name \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian Statement**

1. I/we the undersigned parent(s) guardian(s) of \_\_\_\_\_ believe she/he is competent to carry and administer her/his own metered dose inhaler medication at the appropriate time and in the appropriate way/ I/we give my/our permission for her/him to do so.
2. I/We, the undersigned parent (S) guardian(s) of \_\_\_\_\_, request that a school employee assist the student with the self-administration of the above medication according to the physician's instructions. I/we agree to furnish the necessary prescribed medicine in the properly labeled container, to provide replacement medication as necessary, and I/we agree to notify the school nurse immediately if the physician or medication prescription is changed.
3. For students who have a disability that prevents them from self-administration: I/We, the undersigned parent(s)/guardian(s) of \_\_\_\_\_, request that a safe schools employee administer the above medication to the student, according to the provider's instruction. I/We agree to furnish the necessary prescribed medication an I/we agree to notify the school schools employee immediately if the physician or medication prescription is changed.

Parents/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Telephone: Home \_\_\_\_\_

Work \_\_\_\_\_

Cell \_\_\_\_\_