



Rio Rancho Public Schools Asthma/Nebulizer Medication Form

Student Name _____ DOB: _____
Teacher _____ Grade _____ School _____

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** _____

Nebulizer Medication _____ **Dosage** _____ **Route: Nebulizer** _____ **Time** _____

Special Instructions _____

Do you want this medication taken before Physical education class? (circle) **Inhaler** **Nebulizer** **Neither**

Student may carry his/her own MDI? **YES** **NO**. If yes parent will need to provide back-up medication for the Nurse.

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

**** RRPS School Nurses encourage the use of spacers for all Metered Dose Inhalers. ****

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

Green Zone

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. _____

Daily Medication as usual (see above orders)

Yellow Zone

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 _____

Take the following action _____

Contact parent if no improvement.

Red Zone

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 _____

Take the following action _____

Contact Parent _____ **Contact physician** _____ **If no improvement activate 911.**

Physician signature _____ Phone _____ Fax _____

Physician's printed name _____ Date _____

Parent/Guardian Statement

- 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.
- 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.
- For students who have a disability that prevents them from self-administration:** I/We, the undersigned parent(s)/guardian(s) of _____, request that a school nurse/CMA 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 nurse immediately if the physician or medication prescription is changed.

THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) SHALL NOT INCUR ANY LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE STUDENT'S TRANSPORT OR SELF-ADMINISTRATION OF MEDICATION, AND THE PARENT/GUARDIAN SHALL INDEMNIFY AND HOLD HARMLESS THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) AGAINST ANY CLAIMS ARISING OUT OF THE TRANSPORT AND SELF-ADMINISTRATION OF MEDICATION.

Parents/Guardian Signature _____ Date _____

Telephone: Home _____ Work _____ Cell _____

For Office Use Only
Inhaler Medication Expiration Date: _____
Nebulizer Medication Expiration Date: _____