

EXHIBIT NO.

3

DATE:

3-9-5

BILL NO.

HB 396

Asthma Medication in Schools**SAMPLE FORMS**

*These can/will be modified to meet
criteria of Montana Law*

- **Authorization for Administration of Inhaled Asthma Medication**

Medical Provider instructions – what can and cannot be self-administered

Student has been instructed on how and when to use medications

- **Student Agreement - Self-Administration of Medication**

- **Asthma Action Plan**

Kept on file at school with teacher/nurse

Quick reference on specifics for each asthmatic

Triggers

Medication

Exercise

Peak Flow (breathing capacity) status

Emergency numbers, etc



Authorization for Administration of Inhaled Asthma Medication

(Use a separate authorization form for each medication)

School: _____

Student's Name: (First/MI/Last) _____

Sex: (please circle) Female Male

Birthdate: ___/___/___

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician's Name: _____

Telephone Number: _____ Fax Number: _____

Emergency Contact Number: _____

Diagnosis: _____

Name of Medicine: _____

Form: _____ Dose: _____

Is the child knowledgeable about his/her asthma medication? Yes No

Has the child demonstrated the proper technique in administering medication? Yes No

Medicine is administered daily. Time: _____ Yes No

Medicine is administered when needed. Indications: _____

If needed, how soon can administration of medicine be repeated? _____

The medication cannot be repeated more than _____

Side effects: _____

Comments: _____

() I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

() It is my professional opinion that _____ should not be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date: _____

FOR COMPLETION BY PATIENT

Mother's Name: _____

Father's Name: _____

Mother's Work Telephone: _____ Father's Work Telephone: _____

Home Telephone: _____ Emergency Number: _____

Is the child authorized to carry and self-administer inhaled asthma medication? Yes No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature & Date: _____

Self-Administration of Inhaler Medication Student Agreement

Name: _____ Grade: _____

Inhaled Medication: _____ Date: _____

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Make a note of when I use medication at school.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or school health paraprofessional if the following occurs:
 - My symptoms continue or get worse after taking the medication.
 - My symptoms reoccur within 2-3 hours after taking the medication.
 - I think I might be experiencing side effects from my medication.
 - Other _____
- I understand that permission for self-administration of medication may be discontinued if I am unable to follow the safeguards established above.

Signature of Student

Date

- Verbalizes Dose _____
- Verbalizes Asthma Episode Symptoms
- Demonstrates Proper Technique
 - removes cap and shake if applicable
 - attach spacer if applicable
 - breathes out slowly
 - press down inhaler to release medication
 - breathe in slowly
 - hold breath for 10 seconds
 - repeat as directed.
- Verbalizes Safe Use of Inhaler

The student has demonstrated knowledge about and proper use of his/her inhaler.

Signature of Nurse

Date

Asthma Action Plan



General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/Health Care Provider _____ Phone numbers _____
 Physician Signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Mild Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Pre-medication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

Medicine	How Much to Take	When To Take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When To Take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 50 to 80% of personal best or
_____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days
- Change your long-term control medicines by _____
- Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- Take quick-relief treatment again
- Change your long-term control medicines by _____
- Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When To Take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 0 to 50% of personal best or
_____ to _____

Go to the hospital or call for an ambulance if

- Still in the red zone after 15 minutes
- If you have not been able to reach your physician/health care provider for help
- _____

Call an ambulance immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue