American Academy of Allergy Asthma & Immunology®
www.aaaai.org

School Supplementary Treatment Orders

Student Name: _____ **Birthdate:** _____

Asthma Rescue Medications:

See attached **Asthma Action Plan:**

Please follow the treatment plan detailed in the Green zone for activity/exercise treatment and rescue medication plan for Green, Yellow & Red zones, according to asthma symptoms. Rescue medications include: albuterol, levalbuterol, budesonide/formoterol, mometasone/formoterol, and may include an inhaled steroid combined with albuterol or levalbuterol.

Common side effects of these rescue medications include increased heart and respiratory rate, jitteriness, mouth infection. Please rinse mouth out after use. Maximum number of budesonide/formoterol or mometasone/formoterol in one day is: 8 puffs (<12 years), 12 puffs (>12 years).

☐ The student may carry and self-administer their inhalers

Pre-activity treatment, including before physical education/recess, should be given:

☐ With all activity ☐ Only when the child or school staff feels he/she needs it

If a Student is in the Red Zone, immediately give their rescue treatment and call 911.
Please follow school emergency plans, according to school/school system policy.

Controller Medications:

Only the following controller or steroid medications should be administered in school:

	AM Dose	PM Dose

If not listed on the Asthma Action Plan:

Triggers:

School specific triggers include: _____

Asthma Severity: ☐ Intermittent ☐ Mild ☐ Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

Please Contact the Asthma Provider listed here with any questions or concerns regarding these orders, or if the student does not have adequate/correct medications in the school.

Asthma Provider Printed Name & Contact Information:

Asthma Provider Signature: Date:

Parent/Guardian Permission: I give permission for the medications listed in the Asthma Action Plan to be administered in the school by the nurse or other school members in accordance with school policy. I consent to sharing health information between the prescribing health care provider/clinic, the school nurse, and the school medical advisor necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:

For School Use: ☐ School nurse agrees with student self-administering the inhalers

School nurse received/Signature: Date:

Please send a signed copy back to the provider at the contact listed above.

© 2022 American Academy of Allergy, Asthma & Immunology. All Rights Reserved.