Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for School Year _____ (including summer school) School#: _____ Grade: _____

Student Name:_____ Birth Date: _____ Peak Flow Personal Best:_____

Parent/Guardian's Name:_____ Home #:_____ Work #:_____ Cell #:_____

ASTHMA SEVERITY: ❒ Exercise Induced ❒ Intermittent ❒ Mild Persistent ❒ Moderate Persistent ❒ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE

❒ Breathing is good
❒ No cough or wheeze
❒ Can work, exercise, play
❒ Other:_____
❒ Peak flow greater than_____(80% personal best)

CONTROLLER MEDICATIONS – TO BE USED DAILY AT HOME UNLESS OTHERWISE INDICATED

Medication	Dose	Route	Frequency/Time
			❒ School
			❒ School
			❒ School

EXERCISE ZONE

❒ **Prior to exercise/sports/physical education (PE)**

Medication (Rescue Medication)	Dose	Route	Frequency/Time

If using more than twice per week for exercise/ sports/PE notify healthcare provider and parent/guardian

YELLOW ZONE

❒ Cough or cold symptoms
❒ Wheezing
❒ Tight chest or shortness of breath
❒ Cough at night
❒ Other:_____
❒ Peak flow between_____ and _____ (50% - 79% personal best)

RESCUE MEDICATIONS – TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

Medication	Dose	Route	Frequency/Time
			PRN
			PRN

If symptoms do not improve in _____ minutes, notify healthcare provider and parent/guardian.
If using more than twice per week, notify healthcare provider and parent/guardian.

RED ZONE

❒ Medication is not helping within 15-20 minutes
❒ Breathing is hard and fast
❒ Nasal flaring or intercostal retractions
❒ Lips or fingernails blue
❒ Trouble walking or talking
❒ Other:_____
❒ Peak flow greater than_____(50% personal best)

EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911

Medication	Dose	Route	Frequency/Time

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911

Triggers

❒ Chalk dust
❒ Cigarette smoke
❒ Colds/Flu
❒ Dust/Dust mites
❒ Stuffed animals
❒ Carpet
❒ Exercise
❒ Mold
❒ Ozone alert days
❒ Pests
❒ Pets
❒ Plants
❒ Flowers
❒ Cut grass
❒ Pollen
❒ Strong odors
❒ Perfume
❒ Cleaning products
❒ Sudden change in temperature
❒ Wood smoke
❒ Foods
❒ Other
_____
_____
_____
_____
_____
_____

HEALTHCARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications: ❒ Yes ❒ No

Healthcare Provider Name: _____

Signature: _____

Office #: _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child: ❒ is ❒ is not authorized to self-carry his/her medication(s).

Signature: _____

Date: _____

RECEIVED IN HEALTH SUITE BY_____ DATE_____

REVIEWED BY SCHOOL NURSE

Name (Print): _____

Signature: _____

Date: _____

Authorized to self-carry medications: ❒ Yes ❒ No

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)
Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

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