

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

CONTROLLER MEDICATIONS – TO BE USED DAILY AT HOME UNLESS OTHERWISE INDICATED →			
Medication	Dose	Route	Frequency/Time
<input type="checkbox"/> Breathing is good			<input type="checkbox"/> School
<input type="checkbox"/> No cough or wheeze			<input type="checkbox"/> School
<input type="checkbox"/> Can work, exercise, play			<input type="checkbox"/> School
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Peak flow greater than _____ (80% personal best)			

EXERCISE ZONE

Medication (Rescue Medication)	Dose	Route	Frequency/Time
<input type="checkbox"/> Prior to exercise/sports/physical education (PE)			

YELLOW ZONE

RESCUE MEDICATIONS – TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS			
Medication	Dose	Route	Frequency/Time
<input type="checkbox"/> Cough or cold symptoms			PRN
<input type="checkbox"/> Wheezing			PRN
<input type="checkbox"/> Tight chest or shortness of breath			
<input type="checkbox"/> Cough at night			
<input type="checkbox"/> Other: _____			

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

EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911			
Medication	Dose	Route	Frequency/Time
<input type="checkbox"/> Medication is not helping within 15-20 minutes			
<input type="checkbox"/> Breathing is hard and fast			
<input type="checkbox"/> Nasal flaring or intercostal retractions			
<input type="checkbox"/> Lips or fingernails blue			
<input type="checkbox"/> Trouble walking or talking			
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Peak flow greater than _____ (50% personal best)			

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911

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

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 _____
- Other _____
- Other _____
- Other _____
- Other _____
- Other _____

**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: _____

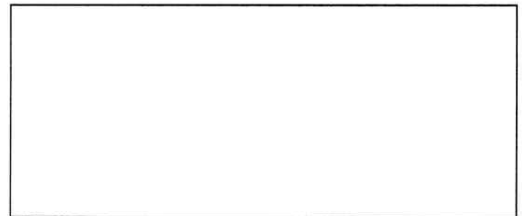
Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

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