

SCHOOL HEALTH SERVICES

MEDICATION REQUEST FORM FOR RESPIRATORY INHALERS

Dear parents/guardian,

For a respiratory inhaler that may need to be administered during the school day, during school-sponsored activities, or while on a school bus or other school property, we must have this form completed by you and by your health care provider. The medication must be supplied by the parent/guardian in its original container from the pharmacy.

Student Name _____ Date of Birth _____

Grade _____ Teacher/First Period Teacher _____

Asthmatic: Yes _____ No _____ Other Diagnosis _____

Allergic to _____

Name of Medicine _____

Dose to be given _____

Frequency/time to be given _____

Student requires supervision: Yes ___ No ___

Student can carry and self-administer Inhaler Yes _____ No _____

Keep Medication in Nurses' Office _____ Return Medication Home _____

Date to stop Medication _____

I give my permission for school personnel to administer prescribed medication listed above. I agree to allow this information to be shared with adults responsible for my child's care. I understand that I am responsible for providing the school with the prescribed Medication in the amount needed and in its original container with label intact as needed by my child. I hereby release Liberty Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Signature of Parent/Guardian _____ **Date** _____

Signature of Prescriber _____ **Date** _____

Printed Name of Prescriber _____

Virginia Asthma Action Plan

School Division: _____


Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone #	Fax # Last flu shot / / /
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email

Asthma Severity: Intermittent or Persistent: Mild Moderate Severe


Asthma Triggers (Things that make your asthma worse)

Colds Smoke (tobacco, incense) Pollen Dust Animals: _____ Strong odors Mold/moisture Stress/Emotions
 Exercise Acid reflux Pests (rodents, cockroaches) Season (circle): Fall, Winter, Spring, Summer Other: _____


Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

<p>You have ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night  <p>Peak flow: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____</p>	<p>Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.</p> <p><input type="checkbox"/> No control medicines required.</p> <p><input type="checkbox"/> Dulera _____ <input type="checkbox"/> Symbicort _____ <input type="checkbox"/> Advair _____, _____ puff (s) _____ times a day <small>Combination medications: inhaled corticosteroid with long-acting β-agonist</small></p> <p><input type="checkbox"/> Alvesco _____ <input type="checkbox"/> Asmanex _____ <input type="checkbox"/> Azmacort _____ <input type="checkbox"/> Flovent _____ <input type="checkbox"/> Pulmicort <input type="checkbox"/> QVAR _____ <small>Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist</small></p> <p>_____ puff (s) MDI _____ times a day Or _____ nebulizer treatment (s) _____ times a day</p> <p><input type="checkbox"/> Singulair or _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small></p> <p>For asthma with exercise, ADD: <input type="checkbox"/> Albuterol or _____, _____ puffs with spacer 15 minutes before exercise</p>
--	--

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Cough or mild wheeze First sign of cold Tight chest Problems sleeping, working, or playing  <p>Peak flow: _____ to _____ (60% - 80% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol or _____, _____ puffs with spacer every _____ hours as needed <small>Inhaled β-agonist</small></p> <p><input type="checkbox"/> Albuterol or _____, one nebulizer treatment (s) every _____ hours as needed <small>Inhaled β-agonist</small></p> <p>Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.</p>
---	--

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show  <p>Peak flow: < _____ (Less than 60% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol or _____, _____ puffs with spacer every 15 minutes, for THREE treatments <small>Inhaled β-agonist</small></p> <p><input type="checkbox"/> Albuterol or _____, one nebulizer treatment every 15 minutes, for THREE treatments <small>Inhaled β-agonist</small></p> <p>Call your doctor while administering the treatments. IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 or go directly to the Emergency Department NOW!</p>
---	--

REQUIRED SIGNATURES:
 I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ Date _____
 SCHOOL NURSE/DESIGNEE _____ Date _____
 OTHER _____ Date _____

CC: Principal Cafeteria Mgr Bus Driver/Transportation
 Coach/PE Office Staff School Staff

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER
CHECK ALL THAT APPLY:

____ Student instructed in proper use of their asthma medications, and in my opinion, **CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.**

____ Student is to notify designated school health officials after using inhaler at school.

____ Student needs supervision or assistance to use inhaler.

____ Student should **NOT** carry inhaler while at school.

MD/NP/PA SIGNATURE: _____ DATE _____