Burlington-Edison School District

HEALTH CARE PROVIDER MEDICATION REQUEST AND TREATMENT PLAN FOR ASTHMA

School Year	**School**	**Fax Number**

_____________________________________ (student) has asthma and may need to take medication at school.
Date of Birth: ____/____/____

The treatment plan for managing asthma at school is as follows: (check all that apply)

❏ Administer rescue medication if student experiences symptoms (coughing, difficulty breathing, wheezing,chest tightness):

Drug and Dosage Form	**Dose, Time, and Mode of Administration**
❏ Albuterol Inhaler ❏ With spacer	❏ 2 (or ____) puffs by mouth 5-20 minutes prior to exercise ❏ 2 (or ____) puffs by mouth every 3-4 hours as needed for symptoms ❏ If no relief after treatment, **call 911.** ❏ Other: ____
❏ Albuterol via Nebulizer ❏ Levalbuteral via nebulizer ❏ Mouthpiece ❏ Mask	❏ 1 unit dose every ______ hours as needed for symptoms ❏ Other: ____
❏ Other: _______________	

❏ Use a peak flow meter per attached directions
❏ Student is to inform school nurse if using albuterol inhaler more than 4 times/day or if asthma causes awakening at night.
❏ Other: ____
❏ Student has been instructed in use of device needed to administer medication.
❏ Student has demonstrated the skill level necessary to use the medication appropriately.
❏ Student recognizes symptoms of asthma and will seek assistance if needed.
❏ Student may carry and self-administer the medication ordered above.

____ Date: ____/_____/_____
(Physician Signature)
____ Fax:________________ Phone:_______________
(Physician Name, *Printed*)

PARENT'S PERMISSION

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, _________________, or allow my child to carry and self administer as indicated above, the medication prescribed by (name of provider) _____________________ for the school year ending June ____. The medication is to be furnished by me in the original container labeled by the pharmacy or healthcare provider with the name of the medicine, the amount to be taken, and when it could be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the healthcare provider's directions. If notified by school personnel that medication remains at the end of the school year, ***I will collect the medication from the school or understand that it will be destroyed.*** I am the parent or legal guardian of the child named.

___________________________________ Work:_______________ Home:_______________
(Parent/Guardian Signature) Cell: ________________ Date: _________

ASTHMA INHALERS AT SCHOOL

Memorandum to Parents

So that the Burlington-Edison School District can better care for your child, please complete this form and return it to the Nurse at your child's school. If any changes occur during the year, please notify the Nurse.

Option #1:

The student comes to the health room where the inhaler is kept, and uses it under supervision. The advantage is that the medication will be used correctly, in the proper amount, and records will be kept. A number of students keep inhalers in the health room and come before PE, recess, or as needed. All medications brought to school must be in their original container, with a signed parental permission note giving the child's name, class, dose, and time for medication to be given.

Option #2:

Qualified students will be allowed to carry their inhalers. The advantage is that it is immediately accessible. A spare inhaler provided by the parent will be kept for them in the health room should they forget theirs or run out.

For permission to carry inhalers:

1. Student must demonstrate to the Nurse correct use of inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees that after two puffs, if there is not marked improvement, s/he will go to see the health assistant immediately.

Student Signature ____

I give my permission for my child _______________________________ to carry the inhaler described below. I understand that s/he must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

NAME OF MEDICATION	**DOSE**	**FREQUENCY OF DOSE**
_______________________________	_____________	_______________________
_______________________________	_____________	_______________________

Parent's signature _______________________________________ **Date** _________________

Special instructions ____

____

Physician's Signature______________________________________ **Date** __________________

The student demonstrates skill level necessary to self-administer medication as ordered above.

School Nurse Signature:____ Date____________