Maryland State School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN ____/____/____ (Date) to ____/____/____ (Date) (not to exceed 12 months)

TRIGGER (LIST)

Child's Name: _____ DOB: _____ 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 MEDICATION - USE 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 the health care 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

If symptoms do not improve in ____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or intercostal retraction
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other: _____
- ☐ Peak flow less than _____ (50% personal best) _____

EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911

Medication	Dose	Route	Frequency/Time

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911.

HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications ◉ Yes ○ No

Health Care Provider Name: _____

Signature: _____

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: _____

REVIEWED BY SCHOOL NURSE

Name: _____

Signature: _____

Date: _____

Authorized to self-carry medications: ◉ Yes ○ No

Asthma Action Plan (continued)

Student's Name: _____ Date of Birth: _____

Teacher's Name: _____ Room #: _____

School will:

- ☐ A Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis, Asthma Signs & Symptoms, and Administration of Inhaler or Nebulizer
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to school staff
- ☐ Have staff trained on individual emergency plans
- ☐ School staff will make every reasonable effort to prevent the student's exposure to known allergens and Asthma triggers
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans
  → for student medication and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide spacer if indicated, as needed by physician
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Come to office to use inhaler prior to exercise
- ☐ Alert nearest adult if they experience any symptoms of Asthma (cough, wheezing, shortness of breath
- ☐ If self-carrying and self-administering, student will demonstrate responsibility by carrying their inhaler and notifying adult when they have used it, and committing to not sharing medication with any other person.

Notes:

Revised May 20, 2015

The Banner School

Student Medications Policy and Procedure

Parents: please read the following and sign below. Return with Physician's Medication Form.

Policy

1. The Banner School will dispense to students only those medications deemed appropriate and prescribed by a licensed physician or nurse practitioner.
2. The Banner School will not dispense any medications or change any dosages or administration times unless authorized in writing by a licensed physician or nurse practitioner.
3. The Banner School does not assume any responsibility for medication that is not prescribed by a licensed physician or nurse practitioner and/or any medication in a student's possession of which the school is unaware.
4. Other than administering the dose at the correct time, The Banner School does not assume responsibility for why a drug is administered, for monitoring its action or any side effects or adverse reactions caused by the drug or combination of drugs that may be administered.
5. Any prescription and non-prescription medication needed on a field trip must have a completed medication order form. The order form and medication must be brought into the front office by a parent no later than five school days before the field trip.

Procedure

1. A Physician's Authorization for Prescription and Non-prescription Medication Form must be filled out and signed by a licensed physician or nurse practitioner for every prescription and non-prescription drug that a student may need to take during the course of the school day and on field trips. Parents are not to complete Part II, only a physician.
2. Parents must bring the completed Physician's Medication Form and the medicine in its original and properly labeled container to the school. The pharmacy label must match the Physician's Medication Form.
3. The delegating nurse will check the drug container and the Medication Form to be sure it is filled out completely. Any drug that is not in a properly labeled, original container, and any form that is illegible or not filled out completely **will be returned to the parent.** It is the responsibility of the parent to be sure the drug is in the appropriate container and to return the form to the physician so that it is filled out completely and correctly.
4. The drug container will be placed in a locked area. The Physician's Medication Form will be placed in the student's medication file.
5. The first dose of any newly prescribed medication must be given at home.
6. The school receptionist will dispense the drug to the student at the designated time. All doses administered are recorded on an administration sheet labeled with the student's name. If the dose is missed, the school receptionist will notify the parent.
7. When the prescribed number of doses have been administered, the school receptionist will indicate this on the administration form and return the empty drug container to the parent. All Physician's Medication Form and drug administration records are retained by the school.
8. All unused and/or unclaimed medication will be destroyed the day after the last day of school.

I understand and agree with the above policy and procedures so that my child can receive his/her medication at The Banner School.

Parent Signature_____ **Date**_____