



# HEALTH CARE PROVIDER MEDICATION REQUEST AND TREATMENT PLAN FOR ASTHMA

| SCHOOL YEAR | SCHOOL | FAX |
|-------------|--------|-----|
|             |        |     |

Student Name, \_\_\_\_\_ has asthma and may need to take medication at school.

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

- Diagnosis:    Intermittent       Mild Persistent       Moderate Persistent       Severe Persistent
- Administer rescue medication if student experiences symptoms *(coughing, difficulty breathing, wheezing, chest tightness)*

| DRUG & DOSAGE FORM   | DOSE, TIME, AND MODE OF ADMINISTRATION  |
|--|---|
| <input type="checkbox"/> Albuterol Inhaler<br><input type="checkbox"/> with spacer   | <input type="checkbox"/> 2 (or _____) puffs by mouth 5-20 minutes prior to exercise, as needed <i>(may repeat with 2)</i><br><input type="checkbox"/> 2 (or _____) puffs by mouth every 3-4 hours as needed for symptoms.<br><input type="checkbox"/> If no relief after treatment, call 911 and notify appropriate staff.<br><input type="checkbox"/> Other: |
| <input type="checkbox"/> Albuterol via Nebulizer<br><input type="checkbox"/> Levalbuterol via Nebulizer<br><input type="checkbox"/> mouthpiece <input type="checkbox"/> mask | <input type="checkbox"/> 1 unit dose every _____ hours as needed for symptoms.<br><input type="checkbox"/> May repeat and call 911<br><input type="checkbox"/> Other:   |
| <input type="checkbox"/> Epi Pen <input type="checkbox"/> Epi Pen Junior   | <b>For severe asthma or allergic emergency</b>  |

- Use 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.

|  |  |     |
|--|--|-----|
| Health Care Provider's Signature             | Phone <i>(for clarification on orders)</i> | Fax |
| Health Care Provider's Printed Name or Stamp | Date                                       |     |

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

**Parent/Guardian's Permission**

I request that the school nurse, principal, or designated staff member be permitted to discuss my child's medical issues with health care providers and to administer to my child, *(name of child)* \_\_\_\_\_, or allow my child to carry and self-administer as indicated above, the medication prescribed by *(name of health care provider)* \_\_\_\_\_ for the \_\_\_\_\_ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should 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 health care 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 the legal guardian of the child named.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Contacts: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

THANK YOU FOR YOUR ASSISTANCE. PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE.  
STUDENT DEMONSTRATES SKILL LEVEL NECESSARY TO SELF-ADMINISTER MEDICATION AS ORDERED ABOVE.

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_