ASTHMA MEDICATION ADMINISTRATION FORM

Student Last Name First Name Middle Initial | Date of Birth ___/___/_____ (MM DD YYYY) | ☐ Male ☐ Female

OSIS # _____ DOE District ___ Grade/Class _____

School Name, Number, Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other:_____

Control *(see NAEPP Guidelines)*
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity *(see NAEPP Guidelines)*
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐Y	☐N	☐U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐Y	☐N	☐U	
History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last : __/__/__
History of asthma-related ER visits within past 12 months	☐Y	☐N	☐U	____ times
History of asthma-related hospitalizations within past 12 months	☐Y	☐N	☐U	____ times
History of food allergy or eczema, specify: _____	☐Y	☐N	☐U	

Student Skill Level *(Select the most appropriate option)*
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers under adult supervision
- ☐ Independent Student: student is self-carry / self-administer

_____ Practitioner Initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Home Medications *(Include over the counter)*
- ☐ Reliever _____
- ☐ Controller _____
- ☐ Other _____

Quick Relief In-School Medication (Select ONE)

☐ **Albuterol MDI**
[*Ventolin® MDI can be provided by school for shared usage (plus individual spacer)*]:
- ☐ MDI w/ spacer
- ☐ DPI

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐___ hrs

In-School Instructions *(Check all that apply)*

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress*: Call 911 and give 6 puffs/1 AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare** *(Within 5 days)*: 2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration
(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone MDI**
[*Flovent® 110 mcg MDI can be provided by school for shared usage*]:
- ☐ MDI w/ spacer
- ☐ DPI

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐ ___ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM

Special Instructions:

Health Care Practitioner (Please Print Name) Last First		Signature	Date ___/___/_____
Address	Tel. (___)___-____	Fax (___)___-____	NPI # _____
Email Address	NYS License # **(Required)**		CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. REV 3/18
FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

ASTHMA MEDICATION ADMINISTRATION FORM

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment, including non-Ventolin inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will get another medicine for my child to use when he or she is not in school or is on a school trip.
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the doctor's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), the Office of School Health (OSH) may provide health services to my child. These services may include a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner will fill out a new MAF so my child can continue to receive health services through OSH. OSH will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.
   - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF ADMINISTRATION OF MEDICINE:

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.
- I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma medicine is not available.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name _____ First _____ MI _____ | Date of Birth __ __/__ __/__ __ __ __

Parent/Guardian Print Name: _____ SIGN HERE **Signature:** _____

Date Signed __ __/__ __/__ __ __ __ Parent/Guardian's Address: _____

Cell Phone (_ _ _) _ _ _-_ _ _ _ Other Phone (_ _ _) _ _ _-_ _ _ _ **Email:** _____

Alternate Emergency Contact Name: _____ Emergency Contact Phone: (_ _ _) _ _ _-_ _ _ _

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: _ _ _ _ _ _ _ _ _ ☐ 504 ☐ IEP ☐ Other

Received By Name: _____ Date __ __/__ __/__ __ | Reviewed By Name: _____ Date __ __/__ __/__ __

Services Provided By
☐ Nurse/NP ☐ School-Based Health Center ☐ OSH Public Health Advisor *(For supervised students only)* ☐ OSH Asthma Case Manager *(For supervised students only)*

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): _____

*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, mouthing words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.

Confidential information should not be sent by email

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year **2018-2019**

DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
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   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will get another medicine for my child to use when he or she is not in school or is on a school trip.
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
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   - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.
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Student Last Name	First	MI	Date of Birth __ __/__ __/__ __ __ __

Parent/Guardian Print Name: _____ SIGN HERE **Signature:** _____

Date Signed __ __/__ __/__ __ __ __ Parent/Guardian's Address:

Cell Phone (_ _ _) _ _ _-_ _ _ _ Other Phone (_ _ _) _ _ _-_ _ _ _ **Email:** _____

Alternate Emergency Contact Name: _____ Emergency Contact Phone: (_ _ _) _ _ _-_ _ _ _

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: _ _ _ _ _ _ _ _ _ ☐ 504 ☐ IEP ☐ Other

Received By Name: _____ Date __ __/__ __/__ __ | Reviewed By Name: _____ Date __ __/__ __/__ __

Services Provided By
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Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): _____

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Confidential information should not be sent by email

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2018-2019

DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year.

Student Last Name | First Name | Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

OSIS # __ __ __ __ __ __ __ __ __ | DOE District __ __ | Grade/Class _____

School Name, Number, Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other:_____

Control *(see NAEPP Guidelines)*
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
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History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last : __ __ / __ __ / __ __
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☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐ ___ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM

Special Instructions:

Health Care Practitioner (Please Print Name) Last / First	Signature	Date __ __ / __ __ / __ __ __ __
Address / Tel. (_ _ _) _ _ _ - _ _ _ _	Fax (_ _ _) _ _ _ - _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _
Email Address	NYS License # **(Required)**	CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. REV 3/18
FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔