ASTHMA

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2014–2015

ATTACH STUDENT PHOTO HERE	Student Last Name First Name Middle	Date of birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) ☐ Male ☐ Female
		OSIS # __ __ __ __ __ __ __ __ __
	School (include name, number, address and borough	DOE District __ __ / Grade / Class

The following section to be completed by Student's HEALTH CARE PROVIDER

Diagnosis	Enter ICD code
☐ Asthma	_ _ _ . _ _
☐	_ _ _ . _ _

Select Asthma Severity

☐ Intermittent ☐ Mild / Persistent ☐ Moderate / Persistent ☐ Severe / Persistent

NAEPP guidelines recommend inhaled corticosteroids (ICS) for persistent asthma.

Select In School ASTHMA Medications	In School Instructions

1. Rescue Medications

Stock supply only available for Albuterol (Ventolin®) HFA. (see back)

Choose one:

☐ Albuterol (Ventolin®) HFA (plus individual spacer with mouth piece may be provided by school for shared usage).

☐ _____®HFA (to be provided by parent).

- ☐ May substitute stock Albuterol (Ventolin®) HFA
- ☐ May not substitute stock Albuterol (Ventolin®) HFA

Choose all options that are appropriate

☐ **Student** may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE).

☐ Store medication in medical room & **student** to self-administer with supervision.

☐ Store medication in medical room and **nurse** to administer.

Student to self-administer personal MDI on school trips &/or after-school programs: ☐Yes ☐ No

☐ **Standard order**: 2 puffs Ventolin® HFA OR __ puffs _____® HFA q 4 hours via MDI with spacer PRN for coughing, wheezing, tightness in chest, difficulty breathing or shortness of breath.

- ➢ May repeat in 15 minutes x 2 if no improvement (total of 3 treatments).

☐ **Pre-exercise**: 2 puffs Ventolin® HFA OR __ puffs _____® HFA via MDI with spacer 15-30 minutes before exercise.

☐ **URI or recent asthma flare (within 3-5 days)**: 2 puffs Ventolin® HFA OR puffs _____® @ noon via MDI inhaler with spacer for 3-5 days.

- ➢ URI symptoms can include: itchy watery eyes, nasal drainage and/or congestion, sneezing, sore throat, cough, headache.
- ➢ Asthma flare symptoms can include: shortness of breath, chest tightness or pain, coughing, wheezing.

Instructions for partial or lack of improvement or adverse reaction

☐ If improved, but not enough to return to class, call parent.

☐ If significant respiratory distress persists

- ➢ Call 911
- ➢ Notify parent and PMD.
- ➢ May provide additional puffs as needed until EMS arrives

2. Inhaled corticosteroid (ICS) : _____® HFA

(to be provided by parent).

Choose all options that are appropriate

☐ Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE).

☐ Store medication in medical room & **student** to self-administer with supervision.

☐ Store medication in medical room and **nurse** to administer.

Student to self-administer on school trips and/or after-school programs: ☐ Yes ☐ No

☐ **Standing daily dose**: __ mcg via inhaler q day at ____ AM / PM

Special Instructions

3. Other asthma medication: _____

Preparation/Concentration: _____

Dose: _____ Route: _____

Choose all options that are appropriate

☐ **Student** may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE).

☐ Store medication in medical room & **student** to self-administer with supervision.

☐ Store medication in medical room and **nurse** to administer.

Student to self-administer on school trips and/or after-school programs: ☐ Yes ☐ No

☐ **Standing daily dose**: _____at ____ AM / PM

Special Instructions

HOME Medications (include over-the counter)	For DOHMH Only
	Revisions per DOHMH after consultation with prescribing provider. ☐ IEP

Health Care Practitioner (Please Print) LAST NAME FIRST NAME	Signature	
Address	Tel. (___)___-____	Fax. (___)___-____
E-mail address*	Cell* (___)___-____	
NYS License # (Required) _____ Medicaid# __ __ __ __ __ __ __	NPI # __ __ __ __ __ __ __ __ __ __	Date __ __ / __ __ / __ __ __ __

The CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

*Confidential information should not be sent by e-mail.

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Authorization for Administration of Medication to Students for School Year 2014–2015

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 26, 2015 (This prescription may be extended through August if the student is attending a New York City Department of Education (the "Department") sponsored summer instruction program); or (2) such time that I deliver to the principal or his/her designee(s) and nurse a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the Department, DOHMH and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department, DOHMH and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize the Department, DOHMH, their agents and employees; including the principal, his/her designee(s), school nurse and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner with the school. In addition, I agree to provide "back up" medication in a clearly labeled bottle to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I also authorize the principal, his/her designee(s) and school nurse to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.

You must send your child's Personal Metered Dose Inhaler (MDI) with your child on a school trip day in order that he/she has it available.

The stock Ventolin is only for use while your child is in the school building.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed __ __ / __ __ / __ __ __ __	Parent/Guardian's Address
Telephone Numbers: Daytime (__ __ __) __ __ __ - __ __ __ __ Home (__ __ __) __ __ __ - __ __ __ __ Cell Phone* (__ __ __) __ __ __ - __ __ __ __	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	Contact Telephone Number (__ __ __) __ __ __ - __ __ __ __
DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY	
Received by: Name Date __ __ / __ __ / __ __ __ __	Reviewed by: Name Date __ __ / __ __ / __ __ __ __
Self-Administers/Self-Carries: ☐ Yes ☐ No	Services provided by: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD):	

*Confidential information should not be sent by e-mail.