FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

AUTHORIZATION FOR ADMINISTRATION OF METERED DOSE INHALER AT SCHOOL

Name of Student _____ Birth Date _____

School_____ Teacher_____

THIS PORTION TO BE COMPLETED BY STUDENT'S LICENSED HEALTH CARE PROVIDER

The school accepts no responsibility for unknown reactions when the medication is dispensed in accordance with the directions of the student's physician or dentist. Orders must be nondiscretionary and legible. **ONLY ONE MEDICATION PER FORM**

THIS STUDENT HAS A DIAGNOSIS OF ASTHMA: ☐yes; ☐no.
If yes, complete 'Asthma Action Plan' on reverse side.
STUDENT HAS PEAK FLOW METER AND PLAN FOR SCHOOL: ☐yes; ☐no.

Name of Medication: _____

Inhaler Dosage:_____

Inhaler will be located (check all that apply):
___ Office
___ On student (practitioner verifies that student is competent in self-administration)

Time(s) of Dosage(s): _____

Anticipated action of Medication: _____

Length of Prescription Period: From _____ To _____

Possible side effects:_____

Emergency measures in case of serious side effect: _____

I certify that valid health reasons exist requiring that the medication be administered during school hours or during such time that the student is under supervision of school officials. I request and authorize that the above-named student be administered or self-administer the above-identified medication in accordance with the instructions indicated. I certify that the student has demonstrated to me or my designee, the skill level necessary to self-administer medication if it is prescribed as self-administered.

_____ _____
Date of Signature Signature of Licensed Health Care Provider

THIS PORTION OF FORM TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I have read this form and **Guidelines for Parent/Guardian Regarding Oral Medications in School** and request and authorize the school to administer the medication prescribed, or for my student to self-administer in accordance with the instructions indicated and the medication identified on this form by the licensed health care provider. I certify that my student has the skill level necessary to self-administer medication in accordance with this prescription and Ferndale School District policy and procedure if self-administration is indicated on this form.

I understand the medication must be furnished in an original container from the pharmacy with the student's name and the name of the medication. All medication must be in a form ready to be administered and must not require any preparation by building staff. It is the parent's responsibility to deliver and maintain an adequate supply of the medication at school or self-carried by the student.

I understand that my signature indicates that the school accepts no liability for unknown reactions when the medication is administered in accordance with the physician's directions. I also understand that because of the school's schedule and the other responsibilities of school staff members, there may be occasions in which a dosage may be delayed or missed. If there is any medication left at the end of the school year, it will be destroyed if I do not pick it up within five (5) working days following the last school day of the current year. If self-medication is indicated, the school will assume no responsibility or liability for the administration of the medication or recording how often it is used.

Parent/Guardian Signature _____ Date_____
Telephone number: _____ _____
Home Work

ASTHMA ACTION PLAN

KNOWN ASTHMA TRIGGERS: _____

WARNING SIGNS OF AN ASTHMA ATTACK:

- Constant cough
- Difficulty breathing with struggling or gasping for breath, or an audible wheeze with breathing
- Stooped body posture
- Trouble walking or talking, or stops playing and can't start activity again
- Lips or fingernails are grey or blue (light complexion only)
- No improvement 15-20 minutes after initial treatment with medication
- _____

EMERGENCY RESCUE PLAN:

1. Call 7-911 if student is having severe symptoms or is unable to walk.
2. Give EpiPen if ordered and available following instructions on EpiPen Care Plan.
3. Assist student with medication administration as prescribed. ☐inhaler ☐nebulizer ☐ EpiPen
4. Never send a child with asthma symptoms anywhere alone. Adult should accompany student to office.
5. Assist with peak-flow measurement if ordered after initial treatment.
6. Call 7-911 for difficulty breathing that does not improve 15-20 minutes after medication administration or immediately if symptoms are worsening or no medication is prescribed or available.
7. Notify parents.
8. Remove student from known triggers, if possible.