Steilacoom Historical School District No. 1
511 Chambers Street
Steilacoom, WA 98388
Telephone: (253) 983-2544 Fax: (253) 584-7198

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
☐ Albuterol Inhaler ☐ with spacer	☐ 2 (or_____) puffs by mouth 5-20 minutes prior to exercise, as needed *(may repeat with 2)* ☐ 2 (or_____) puffs by mouth every 3-4 hours as needed for symptoms. ☐ If no relief after treatment, call 911 and notify appropriate staff. ☐ Other:
☐ Albuterol via Nebulizer ☐ Levalbuterol via Nebulizer ☐ mouthpiece ☐ mask	☐ 1 unit dose every _____ hours as needed for symptoms. ☐ May repeat and call 911 ☐ Other:
☐ Epi Pen ☐ Epi Pen Junior	**For severe asthma or allergic emergency**

☐ 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 *(for clarification on orders)* Fax

Health Care Provider's Printed Name or Stamp Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY, INCLUDING SUMMER PROGRAMS.

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: _____