AMSA
ADVANCED MATH & SCIENCE ACADEMY
INTEGRITY · EXCELLENCE · COMMUNITY

201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE
Phone 508 597-2475/2473 Medical FAX 508 485-0825

IMPORTANT PLEASE READ

Dear Parents/Guardians

If medication(s) is required for administration for next school year (08-24 to 06-25) please remember to follow these important steps:

- Download the appropriate forms from our website. Parents will be able to download the forms from our website, https://www.amsacs.org/, [illegible], Click Parents-Health Office-Medical Forms).
- Orders must be written, and are only active for the current school year. (**Need to be dated after 07-01-24**)
- **Physicians have their own office forms for medication orders and actions plans (allergy/asthma/diabetic/seizure action). It is the parents responsibility to request these forms from your child's physician. Please remeber we cannot administer medications without those forms.**
- **Physicians must provide medication orders that include the name of the medication, form of medication (tablet/capsule/ liquid/injection), frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.**
- **Physicians must provide any action plans. If your child is having medication ordered for allergies/asthma/ diabetes/seizures, then the Physician must supply an Action plan for that specific medication.**
- No order can be accepted that is dated before 07-01-24. Please have the physician date the orders accordingly.
- Remember **only one medication per order form.** Please copy or print additional forms from the website if more forms are needed.
- Please review the AMSACS medication administration policy.
- Bring medications to school before the first day of school in the original container. You may call the health office **after 08-19-24** to arrange drop off. No student is allowed to carry any medications to school, even over-the-counter medications.
- We have included a check list (on the back of this form) for your convenience. **Please print double sided**.

Thank you and have a healthy, happy safe summer ☺

PARENT MEDICATION CHECK LISTS

Checklist for Required Paperwork for **Metered Dose Inhalers**

PHYSICIAN TO PROVIDE:

1. _____ Physician's Order Form
2. _____ Asthma Action Plans (If your child's MD does not have an action plan, he/she must send a note stating they do not have action plan one and why.

Parent to Complete:

1. _____ Parent's Permission for Metered Dose Inhaler Administration
2. _____ Metered Dose Contract to carry
3. _____ Asthma History

If you need this information translated, please copy and paste it into Google Translate. The link to Google Translate is http://translate.google.com/

Spanish
Si necesita que se le traduzca esta información, por favor, copie y pegue en Google Translate. El enlace de Google Translate es http://translate.google.com/

Portuguese
Caso precise traduzir esta informação, por favor, copie-a e cole-a no Google Tradutor. O link para o Google Tradutoré http://translate.google.com/

Chinese
如果您需要翻译此信息，请将其复制并粘贴到 Google 翻译中。 谷歌翻译的链接是 http://translate.google.com/
Rúguǒ nín xūyào fānyì cǐ xìnxī, qǐng jiāng qí fùzhì bìng zhāntiē dào Google fānyì zhōng. Gǔgē fānyì de liànjiē shì http://Translate.Google.Com/

Arabic إذا كنت بحاجة إلى ترجمة هذه المعلومات فالرجاء نسخها ولصقها في ترجمة Google. الرابط إلى ترجمة Google هو : http://translate.google.com/

PARENT/GUARDIAN CONSENT FOR ASTHMA PRESCRIPTION MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

My son/daughter is currently receiving the following medications: (please list all medications the child is receiving, including those given during the school day).

1. _____ 2. _____ 3._____4. _____

My son/daughter has the following food or drug allergies: _____

* * * * * * * * * * * * * * * * * *

Consent

1. I consent to have the school nurse or his/her delegate administer the medication:

   _____

   (Name of medication)

2. I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate (check one) _____ yes _____ no
3. I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
4. I agree to provide unexpired medications in the original, properly dated and labeled container, will keep a dosage count and record of expiration date at home, and will deliver refills as needed. I will promptly pick up any unused medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of this school year.
5. How do you want to handle asthma medication administration during times when your child is attending a school function/event after school hours (clubs/sports, etc.), on during off school activities during day/overnight field trips? (Please check one only)
   a. ☐ COP (Carries on Person @ all times)
   b. ☐ FTAS (Carries only on field trips and afterschool activities)
   c. ☐ DNC (Does not carry Chaperone to carry and be with student during entire event)
   d. ☐ Parent to attend field trip/activity

_____ _____ _____

Parent/Guardian Signature **Relationship to student** Date

_____

FOR HEALTH OFFICE USE ONLY

Asthma history on file: ☐ Grade 06 Date: _____ ☐ Grade 09 Date: _____

Possible Side effects and Required Storage Conditions: See attached form(s) Name of Medication: _____

Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Location where medication administration will occur: ☐ Health Office ☐ Other (specify): _____

Notes/Added Information: _____

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____

Date_____ Date: _____ Date: _____ Date: _____

Contract for Permission to Carry and Self-Administer Inhaler (MDI) 2024-25

Name of Student: _____ Grade: 6 7 8 9 10 11 12

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their metered dose asthma rescue inhalers with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. Please sign at the bottom of this form below and return it to the health office. The school nurse and your child will complete the rest of the form. Please contact the School Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the medication that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that he/she will be responsible for carrying and self-administering this medication while on this field trip only. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement.

Parent/Guardian Signature: Date:

Is Pre-Physical Education Administration required? ☐ Yes ☐ No

CONTRACT AGREEMENT: Check One

☐ COP (Carries on person at all times) ☐ FTAS (Field Trips/Sports/ After School Activities)

☐ DNC (Does Not Carry. Chaperone/coach/club leader carries and student to be with them for duration of event)

☐ Other to be determined by Sch. Nurse: _____

To be completed by School Nurse and Student		
Physicians order for this medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, time it needs to be administrated and purpose of the medication	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use /administration of medication and agrees to carry only the amount of medications required. Amount of medication student can carry is **one MDI**	Yes ☐	No ☐
Student agrees to be responsible to provide and carry his/her own MDI on field trips/after school activities/clubs/sports. If student forgets to bring his/her MDI, & there is no backup in H.O. then 911 will be called if medication is required.	Yes ☐	No ☐
Student agrees that after administering this medication, on field trips/sports/club activities he/she will immediately inform the field trip chaperone/club leader/sports coach etc. of administration.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s) with others.	Yes ☐	No ☐
Student agrees that after administering inhalation medication, if there is not marked improvement, he/she will immediately see the School Nurse or seek medical attention	Yes ☐	No ☐
Student agrees to self-administer MDI in health office. If MDI use is used during school hours at Forekicks, Student agrees to come to health office to report date and time of self-administration.	Yes ☐	No ☐
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes ☐	No ☐
Student agrees to maintain a backup Metered Dose Inhaler in the health Office	Yes ☐	No ☐
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.	Yes ☐	No ☐
Expiration date on Medication in Health office is _____ Expiration date on Medication student is carrying is _____		
I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours. Student Signature: Date:		
This student ☐ does ☐ does not demonstrate the required responsibilities This student ☐ may ☐ may not carry/self-administer the medication. This student may self-administer their MDI prior to/during Phy. Edu. ☐ Yes ☐ No Nurse Signature: Date:		

Asthma Health History 2024-25 (to be completed by parent/guardian)

Name: _____ **Grade:** 6 7 8 9 10 11 12 **Date:** _____

1	Has your child had any emergency room visits or hospital admissions due to asthma? If so when?	☐ Yes ☐ No Explain :
2	When did your child develop asthma?	
3	When is your child's asthma active?	
4	What symptoms does your child exhibit during an asthma onset and episode?	
5	Does your child use an inhaler, if so what type and dose and how often?	☐ Yes ☐ No Medication:
6	Does your child use a spacer?	☐ Yes ☐ No Explain:
7	Does your child use peak flow meters and readings for treatment guidance?	☐ Yes ☐ No Explain:
8	Is your child able to administer their own Inhaler?	☐ Yes ☐ No
9	How do you want to handle field trips?	Please check type of Contract to carry status ☐ Carries On Person (Will always carry) ☐ Field trips and Afterschool Activities Only ☐ Does Not Carry (teacher/coach to carry and student to be with chaperone). ☐ Other
10	Other Medical Conditions Your Child Has? (Important for ER physician)	
11	List all medications, prescriptions, over the counter, herbal, etc. your child takes regularly or occasionally. (Important for ER physician)	

Please be aware that if you feel your child has needs beyond the physicians and nurse's asthma/allergy action plans you may call Guidance for a 504 Plan