SCHOOL MEDICATION PERMISSION FORM

Student Name:_______________________________________ Date of Birth _______ Grade/Class ____ Teacher:__________ School ____________________

TO BE COMPLETED BY HEALTH CARE PROVIDER *Please print clearly and complete **ALL** sections.*

NAME OF MEDICATION (If medication is for asthma reverse side of form MUST be completed by health care provider and parent.)	**STRENGTH**	**DOSE**	**ROUTE (circle)**	**FREQUENCY (include minimum time interval for prn dosing)**	**DIAGNOSIS**	**START DATE**	**STOP DATE**
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	___________________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR AUG 20, 20___
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	___________________ OR as needed every ______ hours		__/__	__/__ OR END OF SCHOOL YEAR AUG 20, 20___
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	___________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR AUG 20, 20___

Precautions and/or adverse reactions to report____

Date: _____ Health Care Provider Signature: ____________________________________ Health Care Provider Name _____________________________

Address____ Phone Number: ______________________ Fax Number: ______________________

TO BE COMPLETED BY PARENT OR GUARDIAN: I give my permission for (Name of child)_____________________________) to receive the medications listed above at school according to standard school policy. The school nurse (or other school personnel) involved with the supervision of my child's health) has my permission to exchange health information with the health care provider.

Parent/Guardian Signature: _______________________________ Parent/Guardian Name: _______________________ Date: ____________

Parent/Guardian Phone Numbers: Cell __________________ Home________________Work_______________ Other ____________

Please note: *Medication must be delivered to school by a responsible adult in the container in which it was dispensed by the prescribing health care provider, licensed pharmacist or pharmacy. If the medication or dosage is changed, a new form must be completed.* ***THIS FORM MUST BE COMPLETED EVERY SCHOOL YEAR.***

TO BE COMPLETED BY SCHOOL: Date received at school: _________ School Nurse Signature:_________________________

Principal Signature:_________________________

Rev. Shaker Schools January 23, 2017

ASTHMA ACTION PLAN

Student Name_____ **Homeroom Teacher**_____

TO BE COMPLETED BY PHYSICIAN

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise**

allergy (please specify)_____ **other trigger(s)**_____

Current medications for asthma control:_____

_____

Asthma medication to be given at camp:_____

_____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: A school district may choose to follow more restrictive procedures regarding student's self-administration.

If an asthma attack occurs, follow these steps:

1._____

2._____

3._____

4._____

Other special instructions: _____

Date: _____Physician's Signature:_____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

- if symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.
- if my child self-administers asthma medication in locations other than in the presence of the camp nurse, it is my responsibility to review with my child when he/she should seek medical assistance.
- if I am not available at numbers listed on reverse side, contact:

Name_____ **Phone Number**_____

Additional Comments:_____

_____

Parent/Guardian Signature_____**Date**_____

TO BE COMPLETED BY SCHOOL

Date received at school/camp_____ **Nurse Signature**_____