Health Care Provider Medication Request and Treatment Plan for Respiratory Conditions

Student Name	DOB	School	Fax	School Year

The above student has _____ (Respiratory Condition) and may need to take medication at school.

The treatment plan for managing this condition at school is as follows: *(check all that apply)*

Severity: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Symptoms may include coughing, difficulty breathing, wheezing, chest tightness, and _____

Triggers may include _____

Drug & Dosage	Dose, Time, and Mode of Administration
❑ Albuterol Inhaler ❑ Other _____ With spacer ❑ Yes* ❑ No ❑ *Permissible to administer without spacer, if not available	**Exercise** ☐ _____ puffs by mouth _____ minutes prior to exercise* *Exercise is defined as: _____ (P.E., Recess, etc.) **Symptoms** ☐ _____ puffs by mouth every _____ hours as needed for symptoms ☐ Regardless of pre-exercise dosing ☐ If no improvement within _____ Min, may repeat _____ puffs, should symptoms worsen/change. ☐ Not to exceed _____ puffs in _____ hours (To include Exercise and Symptom treatment) ☐ Other: _____ **Call 911 if symptoms not improving**
☐ Albuterol via Nebulizer ❑ Other _____	**Indications:** _____ ☐ 1 unit dose every _____ hours as needed for symptoms. ☐ May repeat in _____ minutes and call 911 ☐ Other: _____
☐ Epinephrine* *See separate order set for epinephrine.	For severe respiratory emergency

❑ Student recognizes symptoms and has been instructed in use of device needed to administer medication.
❑ Student may carry the medication ordered above.
❑ Student may self-administer the medication ordered above.
❑ Other: _____

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.

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.

School Nurse Signature: _____ Date: _____