ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2026-2027

Student Last Name First Name Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

Grade/Class _____

School Name

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
☐ Asthma

Control *(see NAEPP Guidelines)*
☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

Severity *(see NAEPP Guidelines)*
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐Y	☐N	☐U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐Y	☐N	☐U	
History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last : __ __ / __ __ / __ __
History of asthma-related ER visits within past 12 months	☐Y	☐N	☐U	____ times
History of asthma-related hospitalizations within past 12 months	☐Y	☐N	☐U	____ times
History of food allergy or eczema, specify: _____	☐Y	☐N	☐U	

Student Skill Level *(Select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision
☐ Independent Student: student is self-carry / self-administer

_____ Practitioner Initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Home Medications *(Include over the counter)*
☐ Reliever _____
☐ Controller _____
☐ Other _____

Quick Relief In-School Medication (Select ONE)

☐ **Albuterol MDI**
[*Ventolin® MDI can be provided by school for shared usage (plus individual spacer)*]:
☐ MDI w/ spacer
☐ DPI

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐ ___ hrs

In-School Instructions *(Check all that apply)*

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE.**
If in Respiratory Distress*: Call 911 and give 6 puffs/1 AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare** *(Within 5 days)*:
2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration
(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone MDI**
[*Flovent® 110 mcg MDI can be provided by school for shared usage*]:
☐ MDI w/ spacer
☐ DPI

☐ **Other:** Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ☐ ___ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM

Special Instructions:

Health Care Practitioner (Please Print Name) Last First		Signature	Date __ __ / __ __ / __ __ __ __
Address	Tel. (_ _ _) _ _ _ - _ _ _ _	Fax (_ _ _) _ _ _ - _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _
Email Address	NYS License # **(Required)**	CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.	

PARENTS MUST SIGN PAGE 2 ➔

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PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
  - I must give the school nurse my child's medicine.
  - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - Prescription medicine must have the original pharmacy label on the box or bottle.
  - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
  - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___ / ___ / _____
Parent/Guardian Print Name:	Signature:
Date Signed ___ / ___ / _____	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ___ / ___ / _____