

Danville School District No. 118

Request for Self-Administration of Asthma Medication

Request for Self-Administration of Allergy Medication (Epinephrine Auto-Injector)

Part 1: To be completed by a Physician licensed to practice medicine in all branches, Physician Assistant or Advanced Practice Registered Nurse

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Frequency & Time of Administration: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

I, \_\_\_\_\_, have in-serviced the above named student regarding the prescribed inhaler or the epinephrine auto-injector and its proper use. I am requesting that he/she be allowed to carry the inhaler or the epinephrine auto-injector on his/her person and assume full responsibility for its use during school hours and extracurricular activities.

Licensed Prescriber (print) \* \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

\* Health Care Provider: Please complete the Asthma Action Plan on the reverse side of this sheet.

Part 2: To be completed by the parent or legal guardian

I \_\_\_\_\_, request and give permission for my son/daughter to carry the prescribed inhaler or epinephrine auto-injector on his/her person. I accept full responsibility for my child's ability to properly use the inhaler or epinephrine auto-injector. I hereby release Danville District No. 118 and its employees from any responsibility to the use/misuse of the inhaler or epinephrine auto-injector by my son/daughter. I will obtain a new doctor's order if there is a change in the prescribed inhaler or epinephrine auto-injector. Lastly, I hereby give permission for the school nurse to discuss the details of this order with the Licensed Prescriber.

Date: \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

## ASTHMA HEALTH CARE PLAN

<b>Name:</b>		
Regular HCP <input type="checkbox"/> 504 HCP <input type="checkbox"/>	Date:	
School:	Grade:	
	Birth Date:	
What Triggers Asthma Problems:		

<p style="text-align: center;"><b><u>GREEN - MAINTENANCE</u></b></p> <ul style="list-style-type: none"> <li>- Breathing is good</li> <li>- No coughing or wheezing</li> <li>- Can work &amp; play</li> </ul> <p style="text-align: center;"><b>Peak Flow Number if Available</b> _____ to _____</p>	<p><b><u>Medication &amp; Dose:</u></b></p> <p>_____</p> <p>_____</p> <p><b><u>When to give:</u></b></p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><b><u>YELLOW – CAUTION</u></b></p> <ul style="list-style-type: none"> <li>- Coughing</li> <li>- Wheezing</li> <li>- Tight chest</li> </ul> <p style="text-align: center;"><b>Peak Flow Number if Available</b> _____ to _____</p>	<p><b><u>Medication &amp; Dose:</u></b></p> <p>_____</p> <p>_____</p> <p><b><u>When to give:</u></b></p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><b><u>RED - DANGER</u></b></p> <ul style="list-style-type: none"> <li>- Medicine is not helping</li> <li>- Breathing is hard &amp; fast</li> <li>- Nose opens wide</li> <li>- Can't talk well or walk</li> </ul> <p style="text-align: center;"><b>Peak Flow Number if Available</b> _____ to _____</p>	<p><b><u>Medication &amp; Dose:</u></b></p> <p>_____</p> <p>_____</p> <p><b><u>When to give:</u></b></p> <p>_____</p> <p>_____</p> <p><b><u>DON'T HESITATE TO CALL 911</u></b></p>
<b><u>Health Action Plan:</u></b>	
<b><u>Other health concerns:</u></b>	
Inhaler Use Demonstrated to School Nurse: Yes _____ No _____	
<b><u>Dietary concerns/restrictions:</u></b>	
M.D. Signature*: _____ Date: _____	
* signature required	
<b><u>Primary Care Physician:</u></b>	<b><u>Phone:</u></b>
<b><u>Specialty MD:</u></b>	<b><u>Phone:</u></b>

