



ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2019-2020
Please return to school nurse. Forms submitted after May 31, 2019 may delay processing for new school year.

Student Last Name	First Name	Middle Initial	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
			MM / DD / YYYY	
OSIS #	DOE District	Grade/Class		
School ATSDBN/Name Address, and Borough:				

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis	Control (see NAEPP Guidelines)	Severity (see NAEPP Guidelines)
<input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____	<input type="checkbox"/> Well Controlled <input type="checkbox"/> Not Controlled / Poorly Controlled <input type="checkbox"/> Unknown	<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent

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

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

Student Skill Level (Select the most appropriate option)	<input type="checkbox"/> Independent Student: student is self-carry/self-administer <i>I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.</i>	Practitioner Instate
<input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers under adult supervision		

Quick Relief In-School Medication

<input type="checkbox"/> Albuterol [Only generic Albuterol MDI is provided by school for shared usage] (plus individual spacer): <input type="checkbox"/> Stock <input type="checkbox"/> Parent Provided <input type="checkbox"/> MDI w/ spacer <input type="checkbox"/> DPI	<input type="checkbox"/> Other: Name: _____ Strength: _____ Dose: _____ Route: _____ Frequency: _____ hrs Give _____ puffs/_____ AMP q _____ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. 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 _____ puffs/ _____ AMP; may repeat q 20 minutes until EMS arrives.
<input type="checkbox"/> Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. 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; may repeat q 20 minutes until EMS arrives.	<input type="checkbox"/> Pre-exercise: _____ puffs/_____ AMP 15-20 mins before exercise.
<input type="checkbox"/> Pre-exercise: 2 puffs 15-20 mins before exercise.	<input type="checkbox"/> URI Symptoms or Recent Asthma Flare: _____ puffs/_____ AMP @ noon for 5 school days Special Instructions: _____
<input type="checkbox"/> URI Symptoms or Recent Asthma Flare: 2 puffs @ noon for 5 school days. Special Instructions: _____	

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

<input type="checkbox"/> Fluticasone [Only Flovent® 110 mcg MDI is provided by school for shared usage] <input type="checkbox"/> Stock <input type="checkbox"/> Parent Provided <input type="checkbox"/> MDI w/ spacer <input type="checkbox"/> DPI	<input type="checkbox"/> Other ICS Standing Daily Dose: Name: _____ Strength: _____ Dose: _____ Route: _____ Frequency: _____ hrs
Standing Daily Dose: _____ puffs ONCE a day at _____ AM Special Instructions: _____	

Home Medications (Include over the counter)

Reliever _____ Controller _____ Other _____

Health Care Practitioner (Please print name and circle one: MD, DO, NP, PA)		Signature	Date
Last	First		___ / ___ / ___
Address		Tel. (___) _____	Fax (___) _____
Email Address		NYS License # (Required)	CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. REV 3/19
FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 →

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PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
 - I must give the school nurse my child's medicine and equipment, including non-albuterol inhalers.
 - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.
 - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
 - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma medicine is not available.
 - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions.
 - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
 - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
 - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
 - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner will fill out a new MAF so my child can continue to receive health services through OSH. OSH will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
 - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
 - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/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. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- 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.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name	First	MI	Date of Birth
School ATSDBN/Name		District	Borough
Parent/Guardian Print Name: _____		SIGN HERE →	Signature: _____
Date Signed	Parent/Guardian's Address:		
Cell Phone (____) _____	Other Phone (____) _____	Email: _____	
Other Emergency Contact Name/Relationship: _____		Emergency Contact Phone: (____) _____	

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: _____	<input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> Other
Received By Name: _____ Date ____/____/____	Reviewed By Name: _____ Date ____/____/____
Services Provided By: <input type="checkbox"/> Nurse/NP <input type="checkbox"/> School-Based Health Center	<input type="checkbox"/> OSH Public Health Advisor (For supervised students only) <input type="checkbox"/> OSH Asthma Case Manager (For supervised students only)
Revisions per Office of School Health after consultation with prescribing practitioner: <input type="checkbox"/> Modified <input type="checkbox"/> Not Modified	
Signature and Title (RN OR MD/DO/NP): _____	

Confidential information should not be sent by email

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