Pierce County Medical Society

HEALTH CARE PROVIDER MEDICATION REQUEST AND TREATMENT PLAN FOR ASTHMA

School Year	School	Fax

Student Name: _____ has asthma and may need to take medication at school.

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

☐ Administer rescue medication if student experiences symptoms (coughing, difficulty breathing, wheezing, chest tightness):

Drug and Dosage Form	Dose, Time, and Mode of Administration
☐ Albuterol Inhaler ☐ with spacer	☐ 2 (or _____) puffs by mouth 5-20 minutes prior to exercise. ☐ 2 (or _____) puffs by mouth every 3-4 hours as needed for symptoms. ☐ If no relief after treatment, **call 911**. ☐ Other:
☐ Albuterol via Nebulizer ☐ Levalbuterol via Nebulizer ☐ mouthpiece ☐ mask	☐ 1 unit dose every _____ hours as needed for symptoms. ☐ Other:
☐ Other:	

☐ Use peak flow meter per attached directions.

☐ Student is to inform school nurse if using albuterol inhaler more than 4 times/day or if asthma causes awakening at night.

☐ Other: _____

☐ Student has been instructed in use of device needed to administer medication.

☐ Student has demonstrated the skill level necessary to use the medication appropriately.

☐ Student recognizes symptoms of asthma and will seek assistance if needed.

☐ Student may carry and self-administer the medication ordered above.

Health Care Provider's Signature	Telephone	Fax

Health Care Provider's Printed Name or Stamp	Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted 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 ending June _____. 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	Phone Contacts		Date
	Work:	Cell:	
	Home:	Other:	

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above.	
School Nurse Signature:	Date:

5/06