LIBERTY CHRISTIAN ACADEMY

Home of the Bulldogs

SCHOOL HEALTH SERVICES

MEDICATION REQUEST FORM FOR RESPIRATORY INHALERS

Dear parents/guardian,

For a respiratory inhaler that may need to be administered during the school day, during school-sponsored activities, or while on a school bus or other school property, we must have this form completed by you and by your health care provider. The medication must be supplied by the parent/guardian in its original container from the pharmacy.

Student Name_____Date of Birth_____

Grade_____ Teacher/First Period Teacher_____

Asthmatic: Yes_____ No_____ Other Diagnosis _____

Allergic to_____

Name of Medicine_____

Dose to be given_____

Frequency/time to be given_____

Student requires supervision: Yes___ No ___

Student can carry and self-administer Inhaler Yes_____ No_____

Keep Medication in Nurses' Office ____ Return Medication Home___

Date to stop Medication _____

At the end of the school year, please return my child's medicine by (check one):

☐ Sending it home with my child ☐ Holding all medicine in the clinic to be picked up by parents

(all medicine will need to be picked up no later than 5/27/22)

I give my permission for school personnel to administer prescribed medication listed above. I agree to allow this information to be shared with adults responsible for my child's care. I understand that I am responsible for providing the school with the prescribed Medication in the amount needed and in its original container with label intact as needed by my child. I hereby release Liberty Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Signature of Parent/Guardian_____ **Date**_____

Signature of Prescriber _____ **Date** _____

Printed Name of Prescriber_____

Virginia Asthma Action Plan

School Division: _____

Name	**Date of Birth**		**Effective Dates** / / to / /
Health Care Provider	**Provider's Phone #**	**Fax #**	**Last flu shot** / / /
Parent/Guardian	**Parent/Guardian Phone**		**Parent/Guardian Email:**
Additional Emergency Contact	**Contact Phone**		**Contact Email**

Asthma Severity: ☐ **Intermittent** ***or*** **Persistent:** ☐ Mild ☐ Moderate ☐ Severe

Asthma Triggers (Things that make your asthma worse)

☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals:_____ ☐ Strong odors ☐ Mold/moisture ☐ Stress/Emotions

☐Exercise ☐ Acid reflux ☐ Pests (rodents, cockroaches) ☐ Season (circle): Fall, Winter, Spring, Summer ☐ Other:_____

Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow:_____

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.

☐ Dulera _____ ☐ Symbicort _____ ☐ Advair _____ , ____ puff (s) ____ times a day
Combination medications: inhaled corticosteroid with long-acting β-agonist

☐ Alvesco _____☐ Asmanex ____ ☐ Azmacort _____ ☐ Flovent ____☐ Pulmicort ☐ QVAR ____
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist

____ puff (s) MDI ___ times a day **Or** ____ nebulizer treatment (s) ___ times a day

☐ Singulair or _____, take ____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD: ☐ Albuterol or _____, _____ puffs with spacer 15 minutes before exercise

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow: _____ to _____
(60% - 80% of Personal Best)

☐ Albuterol or _____, ____ puffs with spacer every ____ hours as needed
Inhaled β-agonist

☐ Albuterol or _____, one nebulizer treatment (s) every ____ hours as needed
Inhaled β-agonist

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow: < _____
(Less than 60% of Personal Best)

☐ Albuterol or _____, __ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

☐ Albuterol or _____, one nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

Call your doctor while administering the treatments.

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ **Date** _____

SCHOOL NURSE/DESIGNEE _____ **Date** _____

OTHER _____ **Date** _____

CC: ☐ **Principal** ☐ **Cafeteria Mgr** ☐ **Bus Driver/Transportation**
☐ **Coach/PE** ☐ **Office Staff** ☐ **School Staff**

Blank copies of this form may be reproduced or downloaded from www.virginiaasthma.org

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY:

____ **Student instructed in proper use of their asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.**

____ **Student is to notify designated school health officials after using inhaler at school.**

____ **Student needs supervision or assistance to use inhaler.**

____ **Student should NOT carry inhaler while at school.**

MD/NP/PA SIGNATURE: _____ **DATE**_____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11
Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership