ASTHMA

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

ATTACH STUDENT PHOTO HERE	**Student** Last Name First Name Middle	**Date of birth** __ __ / __ __/ __ __ __ __ M M D D Y Y Y Y	☐ Male ☐ Female
		OSIS # __ __ __ __ __ __ __ __ __	
	School (include name, number, address and borough	**DOE District** __ __	**Grade** / **Class**

The following section to be completed by Student's **HEALTH CARE PROVIDER**

Diagnosis	**Select Asthma Severity and Control**
□ Asthma	**Severity:** □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent
Other:	**Control:** □ Well-controlled □ Not Controlled □ Poorly Controlled

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 (e.g. with loss of consciousness or with hypoxic seizure) □ Y □ N □ U
Received oral steroids within past 12 months: ___times □ Y □ N □ U
Date last oral steroids received: __ __ /__ __ /__ __
History of food allergy, eczema, specify_____ □ Y □ N □ U

History of asthma-related:
PICU admissions (ever) □ Y □ N □ U
ER visits within past 12 months: ____times □ Y □ N □ U
Hospitalizations within past 12 months: ____times □ Y □ N □ U

Select In School ASTHMA Medications	**In School Instructions**

1. Rescue Medications

Stock supply only available for Ventolin® (see back)

Choose **ONLY** one:

☐ Ventolin® provided by school for shared usage (plus individual spacer).
☐ Albuterol (with spacer, to be provided by parent).
- □ May substitute stock Ventolin® **

☐ _____ (with spacer, to be provided by parent).
- □ May substitute stock Ventolin® **

Other:

_____ _____ _____ _____
Name Dose Route Frequency

Instructions:

☐ **Standard order**:
Q4 hrs PRN for coughing, wheezing, tightness in chest, difficulty breathing or shortness of breath (ASTHMA FLARE SYMPTOMS). **Follow instructions below:**
- Administer **2 puffs;** may repeat in 20 minutes **ONCE**
- If no improvement, call EMS and give **6 puffs** every 20 minutes until EMS arrives

☐ **Pre-exercise:** Give **2 puffs**15 -20 minutes before exercise.
☐ **URI symptoms or recent asthma flare: (within 3-5 days):**
- Administer **2 puffs**@ noon for 5 days.

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

Choose **ONLY** one and specify name of medication:

☐ Inhaled corticosteroid (ICS) : _____® with spacer
☐ ICS combined with long-acting beta agonist:_____® with spacer

☐ **Standing daily dose**:
___ puffs *once a day* at ____ AM OR ____ PM
OR ___ puffs *twice a day* at ____ AM and ____ PM
Special Instructions:

Choose all options that are appropriate:

☐ **Student** may carry medication & may self-administer**. ****
☐ Store medication in medical room & **student** to self-administer with supervision**
☐ Store medication in medical room and **nurse** to administer.
Student to self-administer** personal MDI on school trips and/or after-school programs. ☐ Yes ☐ No
Has the student demonstrated the proper technique for MDI self-administration? ☐ Yes ☐ No

****PARENTS MUST INITIAL REVERSE SIDE**

HOME Medications (include over-the counter)	**For DOHMH Only**
	Revisions per DOHMH after consultation with prescribing provider. ☐ IEP

Health Care Practitioner LAST NAME (Please Print)	FIRST NAME	Signature		**The CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.**
Address		Tel. (___)___-____	Fax. (___)___-____	
E-mail address*		Cell* (___)___-____		
NYS License # **(Required)** _____	Medicaid# __ __ __ __ __ __ __	NPI # __ __ __ __ __ __ __ __ __ __	Date __ __/__ __/__ __ __ __	

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

Confidential information should not be sent by e-mail.

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MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2016 (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse and the principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by DOE and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the OSH, DOE and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I also authorize the school nurse, the principal, and/or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ **I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.**

*You must send your child's **Personal Metered Dose Inhaler (MDI)** with your child on a **school trip day** in order that he/she has it available.*
*The stock Ventolin is **only** for use while your child is in the school building.*

Parent/Guardian's Signature	**Print Parent/Guardian's Name**
Date Signed __ __ / __ __ / __ __ __ __	**Parent/Guardian's Address**
Telephone Numbers: **Daytime** (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone*** (__ __ __) __ __ __ - __ __ __ __	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __
DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY	
Received by: Name Date __ __/__ __/__ __ __ __	**Reviewed by**: Name Date __ __/__ __/__ __ __ __
Self-Administers/Self-Carries: ☐ Yes ☐ No	**Services provided by**: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD):	