PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
OR
SHORT TERM PRESCRIPTION MEDICATION (taken less than 14 days)

Student Name: _____ ID#: _____

Date of Birth: _____ School: _____ School Year: _____

Name of medication: _____ Dosage: _____

Time of administration: _____

Special instructions/reason for medication: _____

Will the student be carrying and taking this medication on his/her own? ☐Yes ☐No

Students are not allowed to carry controlled substances (for example, Tylenol #3) and will be required to come to the Health Office to take any medication classed as a controlled substance.

If YES is selected: I/We understand that our child will be responsible for carrying and taking his/her own medication and that he/she is only authorized to carry one day's supply of medication in the ORIGINAL LABELED container indicating the name of the medication and the dose of the medication or dosing recommendations.

A student requiring OTC medication more than 3 times/month or more than 3 consecutive days should be considered for a medical evaluation.

Parent/Guardian Signature: _____ Date: _____

Phone #(s): _____ _____

School Nurse Signature: _____ Date: _____

Date _____ medication brought for storage in the Health Office. **Expiration date**: _____
Amount of medication _____ (two adults count medication and record)

_____ _____
Signature of person counting Signature of person counting

End of Year Instruction:

☐ I will pick up unused medication on the last day of school (medication will be discarded if I do not pick it up by the end of the day)

☐ Please discard unused medication on the last day of school

Date: _____medication ☐ returned ☐destroyed at end of school year.

_____ _____
Signature of person returning/discarding med Signature of person picking up/discarding med

OTC/SHORT TERM PRESCRIPTION INDIVIDUAL MEDICATION LOG

Student Name: _____ DOB: _____ ID#: _____

Name of medication: _____ Dosage: _____

Time of administration/instructions: _____

_____ Nurse signature and initials

_____ Nurse signature and initials

_____ Health assistant signature and initials

_____ Staff signature and initials

_____ Staff signature and initials

_____ Staff signature and initials

ADMINISTRATION LOG

DATE	TIME	INITIALS	PARENT NOTIFIED	DATE	TIME	INITIALS	PARENT NOTIFIED

Parent Authorization for Long Term Prescription Medication Request Form

Student Name: _____ ID# _____

Date of Birth: _____ School: _____ School Year: _____

Name of Medication: _____

Dosage: _____ Time of Administration: _____

Special instructions/reason for medication: _____

Will the student be carrying this medication on his/her person? _____

Will the student be administering the medication on his/her own? _____

Note: Students are NOT allowed to carry controlled substances (for example, Adderall) and will be required to come to the Health Office to take any medication classed as a controlled substance. The prescription medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

Parent Statement: I request that the prescription medication listed below be given to my child (named above).

- I understand that a picture of my child will be placed on the medication card.
- I understand and agree to transport medication adult to adult and not to send it with the child. (For those students riding the bus, the medication should be given to the bus driver and he will give the medication to the staff member on morning bus duty).
- I understand the extent and responsibility of a child carrying his/her own epiPen and/or asthma medication and will sign off that my child is capable of administering medication and aware of how it is to be used.
- I authorize and delegate that in the absence of the school nurse, other school personnel will dispense medication in the designated dosage.
- I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school and its employees for any liability arising out of these arrangements.
- I will notify the school immediately if the medication is changed and understand that the school may contact the health care provider or pharmacist regarding this medication.
- I understand that this medication will be destroyed unless picked up by the end of the last student school day of this year per federal DEA requirements.

Parent Signature: _____ Date: _____

Healthcare Provider Statement: This medication is required during school hours to improve or maintain the health of this student. The nurse or designated school personnel may contact me regarding this medication. The above named child should receive prescribed medication for the following condition:_____

Medication: _____ Prescribed Dosage: _____

Time and dosage given at school:_____ Beginning Date:_____

Possible side effects:

_____

_____

Healthcare Provider Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Healthcare Provider Address:

_____

NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date_____

School District _____ School Name _____

School Nurse / Health Asst. _____ School Phone # / FAX # _____ / _____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name	Date of Birth	Student #
*Health Care Provider Name/Title	Provider's Office Phone / FAX #	
Parent/Guardian	Parent's Phone #s	
Emergency Contact	Contact Phone #s	
Allergies to Medications:		

Date of last medical exam: ___/___/___	Inhaler is kept: ☐ with student ☐ Health Office ☐ Classroom ☐ Other: _____
Date of last Flu Shot: ___/___/___	Inhaler expires on: ___/___/___

Asthma Triggers Identified (Things that make your asthma worse):
☐ Exercise ☐ Colds ☐ Smoke (tobacco, fires, incense) ☐ Pollen ☐ Dust ☐ Strong Odors ☐ Mold/moisture ☐ Stress ☐ Pests (rodents, cockroaches)
☐ Gastroesophogeal reflux ☐ Season: Fall, Winter, Spring, Summer ☐ Animals ☐ Other (food allergies):_____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

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

Green Zone: Go - You're Doing Well! Take Control Medications EVERYDAY to Prevent Symptoms

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Sleep through the night

Peak Flow may be useful for some students.

☐ ***No controller medication is prescribed.***

☐ _____, _____ puff(s) MDI **with spacer** _____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist

☐ _____, _____ nebulizer treatment(s) _____ times a day
Inhaled corticosteroid

☐ _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist — Always rinse mouth after using your daily inhaled medication.

For asthma with exercise, ADD:

☐ _____, _____ puff(s) MDI with spacer 5 to 15 minutes before exercise

Inhalers work better with spacers. Always use a mask when prescribed.

Yellow Zone: Slow Down! Continue Green Zone Medicine & ADD RESCUE Medicines-

You have ***ANY*** of these:
- First signs of a cold
- Cough or mild wheeze
- Exposure to known trigger
- Problems sleeping, playing, or working
- Cough at night

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

☐ _____, _____ puff(s) MDI **with spacer** & every_____ hours as needed
Fast-acting inhaled β-agonist

OR

☐ _____, _____ **nebulizer** treatment(s) & every_____ hours as needed
Fast-acting inhaled β-agonist

Red Zone: DANGER – Get Help! TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

Your asthma is getting worse fast:
- Cannot talk, eat, or walk well
- Medicine is not helping or
- Getting worse, not better
- Breathing hard & fast
- Blue lips & fingernails

DO NOT LEAVE STUDENT ALONE! Call 911 and start treatment then call Parent/Guardian.

☐ _____, _____ puff(s) MDI **with spacer every**_____ **minutes** until EMS arrives
Fast-acting inhaled β-agonist

☐ **For schools with 02:** (Only use Oxygen if Pulse Oximeter available)
Give 02 to keep sat. above 92% unless otherwise contraindicated. Check sat. continually until EMS arrives.

√ *Make an appointment with your doctor within **two days** of an emergency visit, hospitalization, or anytime for **ANY** problem or question about asthma*
School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms
Parents: Call your child's doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

____ Student has been instructed in the proper use of his/her asthma medications and IS ABLE TO CARRY AND SELF-ADMINISTER his/her INHALER AT SCHOOL.

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

____ Student needs supervision or assistance when using inhaler.

____ Student is unable to carry his/her inhaler while at school.

*SIGNATURE/TITLE: _____ DATE: _____

Parent/Guardian:

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

SIGNATURE: _____ DATE: _____

SCHOOL NURSE: _____ DATE: _____