

HEALTH CARE PROVIDER MEDICATION REQUEST & TREATMENT PLAN FOR ASTHMA

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

SCHOOL (please check school of attendance):

- | | | | |
|---|-------------------|---|-------------------|
| <input type="checkbox"/> White River High School | Fax; 360-829-3351 | <input type="checkbox"/> Glacier Middle School | Fax; 360-829-3391 |
| <input type="checkbox"/> Elk Ridge Elementary | Fax; 360-829-3392 | <input type="checkbox"/> Foothills Elementary | Fax; 360-829-3381 |
| <input type="checkbox"/> Mountain Meadow Elementary | Fax; 360-829-3388 | <input type="checkbox"/> Wilkeson Elementary | Fax; 360-829-3386 |
| <input type="checkbox"/> Student Support Services | Fax; 360-829-3958 | <input type="checkbox"/> Kids Klub - Community Activities | Fax; 360-829-3970 |

This section to be filled out by Physician

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

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

- Use peak flow meter per attached directions.
- Student is to inform school nurse if using albuterol inhaler more than 4 x/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	

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 the medication as prescribed above from _____ to _____

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	Home Phone	Work Phone
Date	Cell Phone	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:	
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