Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

Provider Medication Form | The Parkside School | School Year **2023-2024**

Student Last Name First Name Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

Grade/Class _____

School Name Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other:_____

Control (*see NAEPP Guidelines*)
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity (*see NAEPP Guidelines*)
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

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 (loss of consciousness or hypoxic seizure)	Y ☐	N ☐	U ☐	☐	
History of asthma-related PICU admissions (ever)	Y ☐	N ☐	U ☐	☐	
Received oral steroids within past 12 months	Y ☐	N ☐	U ☐	☐	____ times last : __ __ /__ __ /__ __
History of asthma-related ER visits within past 12 months History of	Y ☐	N ☐	U ☐	☐	____ times
asthma-related hospitalizations within past 12 months History of	Y ☐	N ☐	U ☐	☐	____ times
food allergy or eczema, specify: _____	Y ☐	N ☐	U ☐	☐	

Student Skill Level *(Select the most appropriate option)*
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers under adult supervision

☐ Independent Student: student is self-carry/self-administer
I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

_____ Practitioner Initials

Quick Relief In-School Medication

☐ **Albuterol** [*Only generic Albuterol MDI is provided by school for shared usage] (plus individual spacer)*: ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath.
Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give 6 puffs; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** 2 puffs @ noon for 5 school days.

Special Instructions: _____

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Give ___ puffs/____AMP q ___ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give ___ puffs/ ___ AMP; may repeat 20 minutes until EMS arrives.

☐ **Pre-exercise:** ___ puffs/___ AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** ___ puffs/___ AMP @ noon for 5 school days

Special Instructions:_____

Controller Medications for In-School Administration

(*Recommended for Persistent Asthma, per NAEPP Guidelines*)

☐ **Fluticasone** [Only *Flovent® 110 mcg MDI is provided by school for shared usage*]
☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standing Daily Dose:___ puffs ONCE a day at ___ AM

Special Instructions: _____

☐ **Other ICS Standing Daily Dose:**
Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Home Medications *(Include over the counter)*

☐ Reliever _____ ☐ Controller _____ ☐ Other _____

Health Care Practitioner (**Please print name and circle one**: MD, DO, NP, PA) Last First		Signature	Date __ __ /__ __ /__ __ __ __
Address	Tel. (_ _ _) _ _ _ - _ _ _ _	Fax (_ _ _) _ _ _ - _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _
Email Address	NYS License # **(Required)**		CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

PARENTS MUST SIGN PAGE 2 ➔

ASTHMA MEDICATION ADMINISTRATION FORM

Provider Medication Form | The Parkside School | School Year **2023-2024**

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the doctor's instructions**.**
   - The school's agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Parkside school nurse to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by The Parkside School's nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - For purposes of providing care or treatment to my child, The Parkside School nurse may obtain any other information they think is needed about my child's medical condition, medication or treatment. The Parkside School nurse may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine.

Student Last Name First MI Date of Birth __ __/__ __/__ __ __ __

Parent/Guardian Print Name: _____ SIGN HERE **Signature:** _____

Date Signed __ __ / __ __ / __ __ __ __ Parent/Guardian's Address:

Cell Phone (_ _ _) _ _ _ - _ _ _ _ Other Phone (_ _ _) _ _ _ - _ _ _ _ **Email:** _____

Other Emergency Contact Name/Relationship: _____ Emergency Contact Phone: (_ _ _) _ _ _ - _ _ _ _

For Parkside School Administrative Use Only

☐ 504 ☐ IEP ☐ Other

Received By Name: _____ Date __ __/__ __/__ __ Reviewed By Name: _____ Date __ __/__ __/__ __

Services Provided By ☐ Nurse/NP ☐ School-Based Health Center

Revisions per Parkside school nurse after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): _____