**Danville School District No. 118**

**Request for Self-Administration of Asthma Medication**

**Request for Self-Administration of Allergy Medication (Epinephrine Auto-Injector)**

**Part 1: To be completed by a Physician licensed to practice medicine in all branches, Physician Assistant or Advanced Practice Registered Nurse**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route of Administration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency & Time of Administration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have in-serviced the above named student regarding the prescribed inhaler or the epinephrine auto-injector and its proper use. I am requesting that he/she be allowed to carry the inhaler or the epinephrine auto-injector on his/her person and assume full responsibility for its use during school hours and extracurricular activities.

Licensed Prescriber (print) **\***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\* Health Care Provider: Please complete the Asthma**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Action Plan on the reverse side of this sheet.**

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 2: To be completed by the parent or legal guardian**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request and give permission for my son/daughter to carry the prescribed inhaler or epinephrine auto-injector on his/her person. I accept full responsibility for my child’s ability to properly use the inhaler or epinephrine auto-injector. I hereby release Danville District No. 118 and its employees from any responsibility to the use/misuse of the inhaler or epinephrine auto-injector by my son/daughter. I will obtain a new doctor’s order if there is a change in the prescribed inhaler or epinephrine auto-injector. Lastly, I hereby give permission for the school nurse to discuss the details of this order with the Licensed Prescriber.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASTHMA HEALTH CARE PLAN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | |  |
| Regular HCP ❑ 504 HCP ❑ | Date: | |
| School: | | Grade: |
|  | Birth Date: | |
|  | | |
| What Triggers Asthma Problems: | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **GREEN - MAINTENANCE**  - Breathing is good  - No coughing or wheezing  - Can work & play  **Peak Flow Number if Available**  **\_\_\_\_\_\_ to­­­­\_\_\_\_\_\_** | **Medication & Dose:** | | |
|  | | |
|  | | |
| **When to give:** | | |
|  | | |
|  | | |
|  | | |
| **YELLOW – CAUTION**  - Coughing  - Wheezing  - Tight chest  **Peak Flow Number if Available**  **\_\_\_\_\_\_ to \_\_\_\_\_\_** | **Medication & Dose:** | | |
|  | | |
|  | | |
| **When to give:** | | |
|  | | |
|  | | |
|  | | |
| **RED - DANGER**  - Medicine is not helping  - Breathing is hard & fast  - Nose opens wide  - Can’t talk well or walk  **Peak Flow Number if Available**  **\_\_\_\_\_\_to \_\_\_\_\_\_** | **Medication & Dose:** | | |
|  | | |
|  | | |
| **When to give:** | | |
|  | | |
|  | | |
|  | | |
| **DON’T HESITATE TO CALL 911** | | |
| **Health Action Plan:** | | | |
| **Other health concerns:** | | | |
|  | | | |
| **Inhaler Use Demonstrated to School Nurse: Yes\_\_\_\_\_\_ No \_\_\_\_\_\_** | | | |
|  | | | |
| **Dietary concerns/restrictions:** | | | |
|  | | | |
| **M.D. Signature\*:** | | | **Date**: |
| **\* signature required** | | | |
|  | | | |
|  | | | |
| **Primary Care Physician**: | | **Phone**: | |
| **Specialty MD**: | | **Phone**: | |