**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**:  |