Birmingham PUBLIC SCHOOLS

# Permission to Administer Medication

Prescription and/or non-prescription medication that must be taken by students at school requires a written request from the parent/legal guardian together with a written set of instructions from the physician who has ordered the medication. The child's name, doctor's name, name of the medicine, dosage, route, frequency or time of administration, expected duration of medication regimen, possible side effects and special instructions, shall be clearly listed by the doctor on this form. Signatures are required from both the parent/legal guardian and physician. Medication must be in the original container and labeled with child's name, doctor's name, name of the medication, dosage, route, and frequency or time of administration. Please give initial dose of any new non-emergency medication at home; monitor for side effect, reaction.

Student Name _____ Birth Date _____School _____Grade_____

Student Emergency Contact #1_____ Phone Number _____

Student Emergency Contact #2 _____ Phone Number _____

Name of Attending Physician(s) _____

Physician Address _____

Physician Telephone _____Fax_____

**MEDICATION INFORMATION (THIS SECTION SHOULD BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROVIDER)**

**1) Medication Name** _____ **Dose/Quantity**_____ **Route**_____ **Time of Administration** _____

**Reason for Medication**_____ _____

**Adverse Reactions or Side Effects** _____

_____ **Start Date** _____**End Date** (Valid for one school year only)

**2) Medication Name** _____ **Dose/Quantity**_____ **Route**_____ **Time of Administration** _____

**Reason for Medication** _____

**Adverse Reactions or Side Effects** _____

_____ **Start Date** _____**End Date** (Valid for one school year only)

**Physician certifies this student requires the above medication during school hours**.

**Date _____Physician Signature _____ (required for medication administration)**

**PHYSICIAN**: If student requires an EpiPen or Inhaler, and an additional EpiPen or Inhaler is required for bus transportation or other activity, please provide an extra prescription to the parent.

## SELF-POSSESSION/SELF-ADMINISTRATION AUTHORIZATION

**Students may possess/carry and/or self-administer medication only if authorized by the physician and parent/legal guardian.**

This student is capable of □ **self-carrying** □ **self-administering**: □ Epinephrine □ Inhaler

**Physician Signature for student self-carry/administration of EpiPen/Inhaler_____Date _____**

**Parent/Legal Guardian Signature for child to self-carry/administer EpiPen/Inhaler _____Date _____**

A student's authorization to possess and self-administer medication may be limited or revoked by the building principal after consultation with the school nurse and the student's parents/guardian if the student demonstrates an inability to responsibly possess and self-administer such medication. Please contact the building principal to develop a plan to address how to keep a record of administrations and when the student must seek assistance.

## PARENT/LEGAL GUARDIAN AUTHORIZATION

I hereby request that my child be administered medication at school, by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form. I consent and authorize the healthcare provider staff and school to share information as needed to clarify orders and assist with my child's healthcare needs. I agree that information contained herein shall be shared with individuals and staff that need to know.

Parent/Legal Guardian Signature _____ Date _____

Print Parent/Legal Guardian Name _____

## NOTICE OF DISCONTINUATION OF MEDICATION ADMINISTRATION

Please discontinue medication administration described above for my child _____ as of _____

Parent/Legal Guardian Signature _____ Date_____

American Academy of Allergy Asthma & Immunology
www.aaaai.org

School-based Asthma Allergy Anaphylaxis Management PROgram™

# ASTHMA ACTION PLAN

Name: _____ Date: _____

Emergency Contact: _____ Relationship: _____

Cell phone: _____ Work phone: _____

Health Care Provider: _____ Phone number: _____

Personal Best Peak Flow: _____

## GREEN ZONE:
Doing Well

- ✓ No coughing, wheezing, chest tightness, or difficulty breathing
- ✓ Can work, play, exercise, perform usual activities without symptoms
  *OR*
- ✓ Peak flow ____ to ____
  *(80% to 100% of personal best)*

Take these medicines every day for control and maintenance:

| Medicine | How much to take | When and how often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## YELLOW ZONE:
Caution/Getting Worse

- ✓ Coughing, wheezing, chest tightness, or difficulty breathing
- ✓ Symptoms with daily activities, work, play, and exercise
- ✓ Nighttime awakenings with symptoms
  *OR*
- ✓ Peak flow ____ to ____
  *(50% to 80% of personal best)*

CONTINUE your Green Zone medicines PLUS take these quick-relief medicines:

| Medicine | How much to take | When and how often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Call your doctor if you have been in the Yellow Zone for more than 24 hours.**

Also call your doctor if: _____

_____

## RED ZONE:
Alert!

- ✓ Difficulty breathing, coughing, wheezing not helped with medications
- ✓ Trouble walking or talking due to asthma symptoms
- ✓ Not responding to quick relief medication
  *OR*
- ✓ Peak flow is less than ____
  *(50% of personal best)*

**FOR EXTREME TROUBLE BREATHING/SHORTNESS OF BREATH GET IMMEDIATE HELP!**

Take these quick-relief medicines:

| Medicine | How much to take | When and how often |
|---|---|---|
| | | |
| | | |
| | | |

**CALL your doctor NOW.**
**GO to the hospital/emergency department or CALL for an ambulance NOW!**

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