THIS PAGE MUST BE COMPLETED BY A NEW YORK, NEW JERSEY OR CONNECTICUT LICENSED MEDICAL PROVIDER

NOTE: Parent signature required on reverse side of this form.

PRESCRIPTION MEDICATION ADMINISTRATION FORM FOR SCHOOL YEAR 2014/2015

(MEDICAL PROVIDER SHOULD ATTACH AN ACTION PLAN WITH THIS FORM)

Student's Name *(Last, First, Middle)*

____Male ____Female | **Date of Birth** | **Grade/Class**

Diagnosis ASTHMA ☐ Yes ☐ No_____
ADD DIAGNOSIS

Choose Severity:

☐ Intermittent ☐ Mild Persistent*

☐ Moderate Persistent* ☐ Severe Persistent*

Choose One:

☐ Ventolin HFA

☐ _____ HFA (to be provided by parent).
MEDICATION NAME

INDICATE HOME MEDS IN BOTTOM LEFT BOX.

Choose all that apply

❒ **Standard order**. 2 puffs q 4 hrs. via MDI and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total).

❒ **Pre exercise**. 2 puffs via MDI with spacer 15-30 minutes before exercise.

❒ **URI or recent asthma flare** (within 3 days). 2 puffs @ noon via MDI inhaler and spacer for 3-5 days. URI sx can include: Itchy watery eyes, nasal drainage and/or congestion, sneezing, sore throat, cough, headache
Asthma flare: sx can include: Shortness of breath, chest tightness or pain, coughing, wheezing

Instructions for lack of improvement or adverse reaction

If improved, but not enough to return to class, call parent.
If significant respiratory distress persists, call 911 and notify parent and PMD.
May provide additional puffs as needed until EMS arrives.

Please READ carefully!

Early Childhood Division & Lower School students (Classes/Grades 2s - 5) with chronic medical conditions, such as Asthma, severe, life-threatening allergies (anaphylaxis), Epilepsy, Diabetes, must provide two sets of Emergency Medications to school; one set for the Health Office as the "back up" medication only for use while the child is in the school building, and another set for the child's classroom so that his/her teachers have it with them in case of an emergency during off campus events, including field trips, recess, after school programs, etc.

Middle & Upper School Students (Grades 6-12) with chronic medical conditions, such as Asthma, severe, life-threatening allergies (anaphylaxis), Epilepsy, Diabetes, must store "BACK UP" Emergency Medications at school.

The "back up" medication is only for use while the child is in the school building.

*Students in **Grades 6 though 12** MUST carry an additional **inhaler and/or injectable epinephrine** with him/her at all times, in school and during off campus events, including recess, field trips, after school program, etc., in order that he/she has it available in case of an emergency.*

Besides the emergency medications, such as, asthma inhalers and injectable epinephrine, students are NOT permitted to carry or self-administer his or her own prescription or "over-the-counter" (OTC) medications during the school day. All medications must be taken under observation in the School Health Office.

Diagnosis: ALLERGIES __YES__NO

❒ **Foods(list):**_____

❒ **Drugs(list):**_____

❒ **Other(list):**_____

❒ **Epi-Pen Prescribed:**
Intramuscularly into anterolateral aspect of thigh 911 will be called immediately
Select One:

❒ EpiPen Auto-Injector: 0.3 mg/0.3 ml

❒ EpiPen Jr. Auto-Injector: 0.15 mg/0.3 ml

Anti Histamine:

❒ **Prescribed** _____
Dose/Route_____

❒ PRN_____

_____

_____
Specific signs, symptoms or situations

Any repeats if no improvement?

❒ Yes, in ____ mins, max ____ times (3 total

Conditions under which medication should not be given:

❒ **Seizure Disorder**

❒ **Diabetes**

❒ **ADHD/ADD**

❒ **Other Diagnosis:** _____

Dose/Route:

❒ Diagnosis substantially controlled with medication.

❒ Diagnosis not substantially controlled with medication.

❒ Standing daily dose. Specify time(s)_____
AND/OR
PRN _____
Specific signs, symptoms or situations
Time interval: q _____ min/hrs as needed
Any repeats if no improvement?

☐ Yes, in _____ min/hrs, max _____ times

Conditions under which medication should not be given:

List medication(s) student takes at home and at what time:

Physician Name & Address

Tel. No **Fax No.** License No. and State

Signature

PRESCRIPTION MEDICATION ADMINISTRATION FORM (PMAF): PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION 2014-2015

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician.

I understand that I must provide the School Health Office with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, licensed prescriber's name, date, name of medication, dosage, route and frequency of administration, expiration date and/or other directions; over the counter medications must be in the manufacturer's original container, with the student's name affixed to that container. **I understand that I must immediately advise the School in writing of any change in the prescription or instructions stated above.**

I understand that this Authorization is only valid for the 2014/2015 school year or (2) such time that I deliver to the health office at school a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. I understand that the Dwight School relies on the accuracy of the information provided in this form. I further understand that the Dwight School personnel are not responsible for any adverse reaction to this medication.

I hereby authorize the School to contact, consult with and obtain any further information appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

I hereby certify that my child is in Early Childhood Division (class 2s-K) or Lower School (grades 1 – 5), therefore, I will provide two sets of emergency medications at school: One for the Health Office, as the "back up" medications only for use while my child is in the school building, and another for my child's classroom, so that his/her teachers have it with them in case of an emergency during off campus events, including field trips, recess, after school programs, etc.

I hereby certify that my child is in Middle or Upper School, therefore I will provide ONE set of emergency medications to the Health Office at school, as the "back up" medications only for use while my child is in the school building. I further hereby certify that my child has been fully instructed and is capable to self-administer prescribed medications for Asthma and/or Allergic Anaphylaxis; therefore I will provide for my child an additional inhaler and/or injectable epinephrine to carry with him/her at all times, in school and during off campus events, including recess, field trips, after school program, etc., in order that he/she has it available in case of an emergency. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school.

Dwight School reserves the right to inform teachers/staff members about the potentially life-threatening illnesses or conditions.

Emergency Authorization: In the event of an emergency, I authorize Dwight School personnel to act in loco parentis, which means "in the place of a parent" and secure proper treatment (ambulance, hospitalization, etc.) for necessary care. I understand that every attempt will be made to reach me as soon as possible.

Please Print Parent/Guardian's Name Below:

_____

Parent/Guardian's Signature **Date Signed**