Physician Treatment Plan for
Self-Administration of
Anaphylaxis or Asthma Medication

Physician to Complete

Student: _____ Birthdate: _____ School: _____

Physician Diagnosis: _____

Medication (to be self administered)	**Purpose**	**Dosage & Time** (regularly administered)	**How Soon Repeated**

Special Circumstances for use: _____

_____

Other medications: _____
(NOT self administered)

_____

Asthma Peak Flow Information:

Green Zone is _____ to _____
(Breathing action is good)

Yellow Zone is _____ to _____ Treatment Action _____
(Caution)

_____

Red Zone is _____ Treatment Action _____
(ALERT)

_____

Skills Necessary for Responsible Self Administration of Medication:

1. Student is capable of identifying individual medication and medication is properly labeled.	Yes	No
2. Student is able to identify specific symptoms and purpose of this prescribed medication.	Yes	No
3. Student is knowledgeable of medication dosage and method of medication administration.	Yes	No
4. Student is knowledgeable of how to access assistance for self in an emergency.	Yes	No
5. Student is capable of self-administering the prescribed medication.	Yes	No
6. Student will carry medication in a responsible manner.	Yes	No
7. Student will not share medications with other students. Any abuse of self-administered medications or this plan will result in the loss of this privilege.	Yes	No

The above student has demonstrated the skills necessary for responsible self administration of medication Yes_____ No_____

This treatment **plan expires at the end of each school year** unless an **earlier date** is noted here: _____

_____ _____ _____

Health Care Provider Signature | Physician (Printed Name) | Today's Date

2-2006

OVER - PARENT AUTHORIZATION

Health Services, USD 489

Authorization for Self-Administration of Anaphylaxis or Asthma Medication, K-12

...to be renewed annually...
Return to School Nurse

Parent to Complete:

Name of Student: _____ Date of Birth: _____ School: _____ Grade: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed. I understand that it is my responsibility to furnish this medication. **I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and agree to release, indemnify and hold the school, and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication.**

I authorize USD 489 School Nurses to exchange information regarding this student's health care and treatment plan with:

Physician _____ **Clinic:** _____
Address _____ **Phone** _____

Signature of Parent _____ **Date** _____
Phone: Home _____ **Work** _____ **Cell** _____

IMPORTANT NOTES:
* The student shall carry, for the purpose of self-administering, only a single day's supply of medication, with the exception of inhalers. The medication must be in the **original, completely labeled container.** If a prescription, it should bear the **pharmacy label with correct, current dosage information.**

* In order for a student to have access to emergency medications at all times, it is recommended that an **additional supply of the listed self-administered medication(s) be kept at the school.**

For School Nurse Use

The above student has demonstrated the skills necessary for responsible self-administration of medication(s). Yes____ No____ _____ _____
school nurse signature date

Teachers responsible for supervision of this student have been notified of permission to carry listed medication(s) and self-medicate on this date _____.

Names of teachers notified: _____

Over for
Physician's Treatment Plan

2-2006