PLEASE DETACH BEFORE COMPLETING

School District: _____ School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None Expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (specify) _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work #: _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION / APPROVAL

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

Prescriber's authorization for self administration: ☐ Yes ☐ No _____
Signature Date

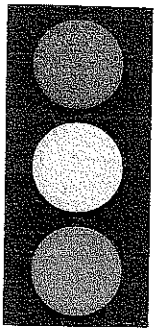
Parent/Guardian authorization for self administration: ☐ Yes ☐ No _____
Signature Date

Asthma Action Plan

Name:		Date:
Birth Date:	Provider Phone #:	Provider Fax #
Patient Goal:		Parent/Guardian Phone #

Important!: Things that make your asthma worse: (Triggers) ☐ dust ☐ pets ☐ mold ☐ smoke ☐ pollen ☐ other_____

Severity: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Mild Intermittent



GO -- You're Doing Well! Use these medicines everyday:

PERSONAL BEST PEAK FLOW: _____

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

OR

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN / WHEN

CAUTION -- Slow Down! Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight Chest
- Coughing at night

OR

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN / WHEN

CALL YOUR HEALTH CARE PROVIDER: _____

DANGER -- Get Help! Take these medicines and call your provider now.

Your Asthma is *getting worse* fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

OR

Peak flow less than _____

MEDICINE	HOW MUCH	HOW OFTEN / WHEN

Get help from a provider now! Do not be afraid of causing a fuss. Your provider will want to see you right away. It's important! If you cannot contact your provider, go directly to the emergency room and bring this form with you. DO NOT WAIT.

Make an appointment with your primary care provider within two days of an ED visit or hospitalization.

Provider Signature: _____ Date: _____

PARENT/GUARDIAN TO COMPLETE THIS SECTION:

I, _____ give permission to the school nurse and/or the school-based health
(parent/guardian name-please print)
clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider _____ Date:_____
(parent/guardian signature)

REFER TO THE BACK OF THE LAST PAGE FOR THE MEDICATION AUTHORIZATION FORM