Bismarck-Henning Community Unit School District #1
Bismarck-Henning Rossville-Alvin Cooperative High School

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): Prescriber Signature:

Address:

City, State, Zip:

Telephone:

Date:

Health Care Provider: Please complete the Asthma Action Plan on the reverse side of this sheet.

****

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 Bismarck-Henning Community Unit School District #1 and Bismarck-Henning Rossville-Alvin Cooperative High School 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.

Date: Parent/Legal Guardian:

Address:

Telephone: City, State, Zip:

Bismarck-Henning Community Unit School District #1
Bismarck-Henning Rossville-Alvin Cooperative High School

ASTHMA HEALTH CARE PLAN

Name: _____

Regular HCP □ 504 HCP □ Date: _____

School: _____

Grade: _____ Birthdate: _____

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: