Oakwood School District #76

Request for: Inhaler and/or Nebulizer Treatments

Student will self-carry and self-administer unless the box below is checked:

❑ **Do not allow student to self-carry or self-administer medication**

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 and its proper use. I am requesting that he/she be allowed to carry the inhaler on his/her person and assume full responsibility for its use during school hours and extracurricular activities.

Licensed Prescriber(print): _____Signature:_____

Address: _____

_____

Telephone:_____

Date:_____

***Health Care Provider: Please complete the Asthma Action Plan on the back of this sheet**

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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 on his/her person. I accept full responsibility for my child's ability to properly use the inhaler. I hereby release Oakwood School Dist. 76 and its employees from any responsibility to the use/misuse of the inhaler by my son/daughter. I will obtain a new doctor's order if there is a change in the prescribed inhaler. Lastly, I hereby give permission for the school nurse to discuss the details of this order with the Licensed Prescriber.

Parent/Guardian signature:_____ Date: _____

Address:_____Phone Number:_____

Oakwood School District #76
Asthma Action Plan

Name:	DOB:	Grade:
Doctor:	Doctor's Phone:	
Parent/Guardian:	Phone Number:	
Parent/Guardian:	Phone Number:	
Emergency Contact:	Phone Number:	

Green → **GO**	**Use these daily medications at home to control your asthma:**		
You have all of these: ● Breathing is good ● No cough or wheeze ● Normal sleep ● Can work or play	**Medicine**	**Dose**	**How often**

Yellow → **CAUTION**	**Continue with green zone medications and add:**		
You have any of these: ● Cough ● Mild wheeze ● Tight chest ● Exposure to known triggers	**Medicine**	**Dose**	**How often**

Red → **DANGER**	**Take these medications and call parent/guardian & 911 NOW!**		
Asthma is worsening: ● Medicine not helping ● Breathing hard and fast ● Nose open wide ● Trouble speaking	**Medicine**	**Dose**	**How often**

Physician Signature:_____ **Date:**_____