Bixby Public Schools Health Services
Inhaled Medications Administration Form

Student Name _____ DOB _____ Grade _____

To Be Completed by Student
I have read and understand the medication policy on the reverse side of this form. I agree to abide by the policy.

Student Signature _____ Date _____

To Be Completed by Parent
I am the parent/guardian with legal custody of the above named student. I have read and understand the medication policy on the reverse side of this form. I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I agree to abide by the medication policy and:

One of the following options must be checked:

- ☐ **Option 1:** I request that my child be allowed to carry and self-administer the physician-ordered medication listed below. I understand that my child and I are responsible for safeguarding the carried medication. I agree to provide the school with an additional supply of the medication ordered below, which can be administered by the school nurse or my child in the event that my child does not have his/her self-carried medication.
- ☐ **Option 2:** I request that a certified school nurse administer the physician-ordered medication listed below. I request that my child be allowed to self-administer the medication in the absence of a school nurse. I understand that I will be notified if my child self-administers this medication. This option requires completion of form H-5A.
- ☐ **Option 3:** I request that a certified school nurse administer the physician ordered medication listed below. In the absence of a school nurse, I request that a designated school employee administer my child's medication. I understand I will be notified if a school employee other than a school nurse administers this medication. This option requires a parent/guardian meeting with the designated school employee(s) and the completion of form H-5A prior to initiation of the plan.

Parent/Guardian Signature _____ Date _____

To Be Completed by Physician

Student Name _____ Diagnosis _____

Medication Order _____

_____

Note: If ordered, p.r.n. the interval for repetition of the dose must be specified.

Side Effects to Expect _____

One of the following options must be checked:

- ☐ **Option 1:** In my professional opinion, it is medically necessary that this student be allowed to carry and self-administer the above medication. I verify that this student has the knowledge and skills to safely administer and safeguard this medication.
- ☐ **Option 2:** I authorize this medication to be administered by a certified school nurse. In the event that a school nurse is not available, I authorize this student to self-administer the above medication. I verify that this student has the knowledge and skills to safely administer this medication. I understand that the student's parent/guardian will be notified if the student self-administers.
- ☐ **Option 3:** I authorize this medication to be administered by a certified school nurse. In the event a school nurse is not available, I understand that the parent/guardian is requesting that a designated school employee administer this medication.

Note: In accordance with Attorney General Opinion 98-24, licensed nurses may not delegate respiratory care therapy to unlicensed persons. **Physician and Parent must choose the same option.**

Physician's Name _____ Phone _____

Physician's Signature _____ Date _____

Bixby Public Schools Health Services
Parent Instructions for Resuming Activities

Student Name _____ Date of Birth _____

When the school nurse is unavailable and a child receives inhaled medication(s), the parent/guardian will be notified as soon as possible. Non-nurse employees of Bixby Public Schools will not be responsible for assessment or determination of the student's condition prior to or after administration of a medication. The parent/guardian will be asked to speak to the child and to determine if the student is able to resume school activities.

If a parent/guardian cannot be reached, the following instructions will be followed.

I am the parent/guardian of the above named child. I have adequately instructed my child and/or Bixby School employees regarding my child's inhaled medication(s). If I cannot be reached after my child has received inhaled medication(s) and the nurse is unavailable:

- ☐ I am providing a peak flow meter. My child may return to class if his/her peak flow is _____or above. If my child's peak flow is below this number, call one of my alternate contacts to pick up my child. If my child's peak flow is below _____ call 911.
- ☐ My child is capable of deciding if he/she is able to resume school activities. If my child states that he/she is unable to resume activities, call one of my alternate contacts to pick up my child.
- ☐ Notify one of my alternate contacts to pick up my child.
- ☐ I request that a school nurse be contacted to evaluate my child when available. I understand that my child will not be allowed to resume school activities until a nurse arrives and evaluates my child.
- ☐ Other (specify) _____

Note: If at any time an employee of Bixby Public Schools believes that an emergency situation is occurring, 911 will be called.

Parent Signature _____Date _____