Medication Packet for Students With Asthma

- Schedule an appointment with your child's health care provider over the summer to update medications and/or obtain new prescriptions.

- Ask physician to complete and sign the Inhaler Self-Carry Form (if you want your child to carry his/her inhaler at school).

- Parent: Complete and sign the Medical Release Form.

- Parent: Read and sign the Medication Authorization Form. A separate form is required for each medication

- Bring all completed forms to the Clinic. Please bring in a new inhaler with the pharmacy label attached.

Authorization to Self-carry/Administration of Metered Dose Inhalers During School and School Sponsored Activities

FS 409.9071 Section 232.47 states that an asthmatic student may be able to carry a metered dose inhaler on their person while in school when they have written approval from the parent/guardian and physician. The principal shall be provided with a copy of this document.

Student_____ DOB _____ Grade_____

School Dommerich Elementary

Medication _____ Dose _____ Time_____

Method of Administration Metered Dose Inhaler Spacer (Y/N) _____

Diagnosis _____ Other _____

Possible Side Effects/Precautions/Recommended Interventions_____

_____

Other_____

Duration (dates) of Administration: From _____ to _____ (Limit: One year).

I request that my child be allowed to carry/self-administer his/her Metered Dose Inhaler medication and be responsible for its proper storage and use. I take responsibility for this permission. I understand that this medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

_____ _____ _____

Parent/Guardian Date Daytime Telephone Number

I have demonstrated the correct use/administration of this medication and agree to terms of this contract. I will keep medication in agreed location, will not share this medication with others, and will come to the health room/clinic if having the following symptoms after using the medication.

_____ _____

Student Date

I authorize this student to carry/self-administer the above medication. He/she has been trained to recognize signs/symptoms of asthma/breathing difficulties and how to correctly use the inhaler by me and/or my office staff.

_____

Physician's Name/Stamp

_____ _____

Physician's Signature Date

☐ Extra Inhaler in Health room ☐ Copy to Principal

Rev 02/10

HEALTHCARE SERVICES LETTER

Dear _____
Physician

_____

_____

Phone #: _____ Fax #: _____

In order to provide health services for: _____, DOB: _____
it is necessary to obtain a medical history, immunization history, and a health plan including a list of current medications administered at home/school.

Please forward all documentation to:

Attn: Danielle Calapa, RN

School: OCPS – Dommerich Elementary

_____

Address: 601 N. Thistle Lane
Maitland, FL 32751

Phone: 407-623-1407 Fax: 407-623-5738

RECORD RELEASE

I hereby give my permission to have any records of my child (health care plans, nursing care plans, immunization history, medical history, and medications) released to my child's school to aid school personnel in serving him/her.

I give my permission for designated school personnel to contact my child's physician regarding current/pending health issues.

_____ _____
Parent/Guardian Date

_____ _____ _____
Home Phone Number Work Phone Cell Number

Teacher:_____ Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to Dommerich Elementary School

To assist_____ DOB ___/___/_____

Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask you pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS**. Notes from home will not be accepted as authorization for dispensing medication.

_____ ___/___/___

Signature of parent/guardian Date

(___)_____ (___)_____ (___)_____

Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.

REV 02/10

Medication Receipt/Pick-up Record

School Year_____

Student Name: _____ School: _____

	Date	Medication/Dose Received	Dose to be given	# Recd	OCPS Staff Signature	Parent/Staff Signature
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

	Date	Medication/Dose Picked up	Amount picked up	OCPS Staff Signature	Parent/Staff signature
1.					
2.					
3.					
4.					
5.					
6.					
7.					