

YOUR ROAD MAP to a SCHOOL MEDICATION FORM for ASTHMA

New York City children with asthma are required to have a Medication Form on file at their school in order to take asthma medicines during the school day. The form is needed in order for school nurses to administer medication and/or for children to carry inhalers for self-administration of prescribed medication. The Medication Form is a two-sided page that comes in a packet of

authorization forms for the provision of health services in schools. A photocopy of an original blank Medication Form is acceptable, but both sides must be copied. The following guide is color-coded for **parents/guardians in RED**, **school staff in GREEN** and **physicians/medical providers in BLUE**. Please do your part to ensure that children with asthma get the medications they need.

- PARENTS/GUARDIANS** fill in top section with information about the child and their school. **1**
- Read and complete back of the form (over).
- Attach a recent photograph of the student to the form.

- SCHOOL STAFF** complete box in upper right corner. **2**
- Review parent/guardian and physician/medical provider sections for completeness.
- Keep extra blank forms available.

*** SAMPLE ***

MULTI-USE MEDICATION FORM
Authorization for Administration of Medication to Students for the School Year 2004-2005

Student's Name (Last, First, Middle) Sample, Student Male Female Date of Birth 00/00/0000 I.D. Number 123456789

Region 01 School PS 00 Grade 00 Class 123 Borough Brooklyn

School Address Street Address Zip Code 11206

FOR DOE/DOHMH USE:
 MS
 S04
 IEP
 SC/SA

Physician's Order

1. Diagnosis ASTHMA Yes No

INDICATE SEVERITY:
 Mild Intermittent Moderate Persistent
 Mild Persistent Severe Persistent

Order for Administration in School

For your convenience, we have pre-printed a standard albuterol order. If you are not in agreement please re-write the order in box #2. If no box is checked, we will implement the first standard order.

Albuterol 2 puffs q 4 hrs. via metered dose inhaler and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total).
 Albuterol 2 puffs via MDI with spacer 15-30 minutes before exercise.

Standing daily dose. Specify time(s):
Conditions under which medication should not be given:

AND/OR

prn _____
specific signs, symptoms or situations

Time interval: q _____ hours as needed
Any repeats if _____ in _____ hr, max _____ times
no improvement? Yes, in _____ min, max _____ times

Instructions in case of lack of improvement or adverse reaction

If improved, but not enough to return to class, call parent. If significant respiratory distress persists, call 911 and notify parent and PMD. May provide additional puffs as needed until EMS arrives.

Choose all that are appropriate

Store medication in medical room and administer under supervision.
 Student may carry medication and may self-administer. (Parent must initial reverse side.)

Column 1

Column 2

Column 3

Column 4

2. Diagnosis _____

Medication/Preparation _____

Dose/Route _____

Diagnosis substantially controlled with medication.
 Diagnosis not substantially controlled with medication.
 Diagnosis self-limited.

3. Diagnosis _____

Medication/Preparation _____

Dose/Route _____

Diagnosis substantially controlled with medication.
 Diagnosis not substantially controlled with medication.
 Diagnosis self-limited.

List medication(s) student is taking at home and at what time:

1. Inhaled Corticosteroid 2 puffs BID with spacer
2. Leukotriene Modifier - 1 Chewable Tab P.O daily

Physician's Name Sample M.D. Physician's Signature Sample M.D.

Physician/Clinic Address Street address Borough, ZIP

Physician/Clinic Tel. No. (718) 123-4567 Physician/Clinic Fax No. (718) 000-0000 NYS Registration No. 123456 Date 00/00/04

FOR DOHMH USE: Revisions per DOHMH

Reminder: Parent must complete and SIGN reverse side and submit a current photograph to be attached to the Medication Form

*DISCLAIMER: Use of brand name medicines in the sample form is for illustrative purposes only and is not an endorsement by DOHMH of any pharmaceutical company or its products.

- PHYSICIANS / MEDICAL PROVIDERS** fill in the Physician's Order section: **3**
 - Column 1** - Check off a classification of asthma severity with an asthma diagnosis.
 - Column 2** - Provide specific indications for administration of PRN medications. Review standard albuterol order and check as appropriate.
 - Column 3** - Write detailed instructions in case of a lack of improvement.
 - Column 4** - Indicate if medication is to be administered under supervision only (check 1st box), if medication can be carried and self-administered (check 2nd box), or BOTH (check both boxes) **4**
- Prescribe 2 MDIs and 2 spacers, indicating that one of each is to be kept at school.
- Box, bottom left** - List other prescribed medications, especially long-term control (anti-inflammatory) meds. **5**
- Box, bottom center** - Fill in physician's name and contact information. **6**
- Complete an Asthma Action Plan to accompany the Medication Form so families can follow treatment plans and use medications correctly.

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The backside of the Medication Form is filled in by parents/guardians and school staff. If any section on the front or backside of the form is incomplete, the form will not be approved.

PARENTS/GUARDIANS

Read and initial here (if applicable) to authorize student to carry and self-administer asthma medicine during the school day. ①

PARENTS/GUARDIANS

Read, sign and date here to authorize administration of asthma medicine at school, in accordance with your physician's orders. ②

This section for use by SCHOOL STAFF only. ③

ADMINISTRATION OF MEDICATION: PARENT/GUARDIAN'S CONSENT, AUTHORIZATION AND RELEASE 2004-2005

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary means of administration of such medication, in accordance with the attached instructions of my child's physician. I understand that the medication is to be furnished by me in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I further understand that I must immediately advise the principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2005 (This prescription may be extended through August if the student is attending a Department of Education sponsored summer program); or (2) such time that I deliver to the principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this Medication Form, I am requesting that my child be provided with specific health services by the New York City Department of Education (the "Department"). I have provided the full and complete information and instructions regarding the provision of the above-requested health service(s) in this Medication Form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information and instructions that I have provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that I have provided in this Medication Form. I understand that it is my responsibility to provide the medication that has been prescribed for my child. I further understand that the Department is not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department of Education to provide the services requested, but rather, my request, consent, authorization and release for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department of Education, its employees and agents, to consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist. I also authorize the principal and/or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

1 **SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph if applicable (for example, for use of an Epi-Pen, asthma inhaler and other medications):**
 I hereby certify that my child has been fully instructed in and is proficient in the self-administration of the above-prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize the Department of Education, its agents and employees, including the principal, his/her designee(s) and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication.

2 **PARENT/GUARDIAN NAME & ADDRESS BELOW: Please Print**
 Parent/Guardian's Signature: Sample Parent
 Date Signed: 06/06/2004
 Daytime Telephone No.: (718) 555-1234 Home Telephone No.: (718) 555-1324
 Street Address: Sample Parent
Borough, ZIP

3 **DO NOT WRITE BELOW (FOR DOE AND DOHMH ONLY)**

| | |
|--|--|
| Received by: _____ | Reviewed by: _____ |
| Name _____ | Name _____ |
| Date _____ | Date _____ |
| Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Services provided by: <input type="checkbox"/> Nurse <input type="checkbox"/> DOHMH Pub Health Adv | |
| <input type="checkbox"/> School Based Clinic <input type="checkbox"/> DOE School Staff | |
| Self-Administers/Self-Carries: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Signature and Title: _____ (RN OR MD) | (Date school notified and form forwarded to DOE Liaison) |

04-05

CALL 311 TO REQUEST A SCHOOL MEDICATION FORM OR AN ASTHMA ACTION PLAN.

