Steubenville City Schools

Authorization for the Administration of Medication/Epi-Peni

Student's Name_____ D.O.B._____ Grade_____

Address_____ School: SHS HMS EAST WELLS WEST

Parent Name_____ Phone #_____

DAILY MEDS MEDICATION	DOSAGE	HOW IT IS TO BE GIVEN	TIME(S) TO BE ADMINISTER	DURATION ALL SCHOOL YR OR SPECIFY	REASON FOR MEDICATION

AS NEEDED MEDS MEDICATION	DOSAGE	HOW IT IS TO BE GIVEN	TIME(S) TO BE ADMINISTER	DURATION ALL SCHOOL YR OR SPECIFY	REASON FOR MEDICATION

Please list any special instructions or possible reactions that should be reported to physician:

_____

_____

PHYSICIAN'S STATEMENT: *The above medication(s) cannot be scheduled for other than school hours.*
Instructions:

Physician's Name_____ Phone #_____

Physician's Signature_____ Date_____

PARENT'S STATEMENT: *I am requesting that appropriate school personnel administer or supervise my child's use of medication as prescribed above. I also agree to submit a revised statement, signed by the physician, to the principal, indicating any changes in the information provided above.*

Parent's Signature_____ Date_____

Principal's Signature_____ Date_____

School Nurse Signature_____ Date_____

STEUBENVILLE CITY SCHOOLS

Parent/Physician Request for the student to carry ***Asthma Inhaler***

Student's Name_____ D.O.B._____ Grade_____

Address_____ School: **SHS HMS EAST WELLS WEST**

Parent Name_____ Phone #_____

MEDICATION	DOSAGE	HOW IT IS TO BE GIVEN	TIME(S) TO BE ADMINISTER	DURATION ALL SCHOOL YR OR SPECIFY	REASON FOR MEDICATION

Procedures to follow in the event that the medication does not produce relief from the student's asthma attack or allergic reaction:

_____

_____

Adverse reactions that should be reported to the physician:

_____

_____

Adverse reactions for unauthorized user:

_____

_____

Other special instructions:

_____

_____

Physician's Name: _____ Phone #_____

Signature: _____ Date: _____

I, the parent/guardian request that medication be administered to my child in accordance with the instructions of our physician. I understand that the administration of said medication is to be done under the supervision of a member of the school staff. I understand that the school personnel are not legally obligated to administer oral medication to any child and, therefore, I agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgement arising out of these arrangement. I will notify the school immediately if we change medication or terminate the use of this medication.

Parent/Guardian Name: _____ Phone # _____

Signature: _____ Date: _____

Principal Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Student Asthma Action Plan

This personalized asthma action card is to help the school staff work with the parents and physicians in controlling asthma for our students. The parent and physician should fill out this form yearly and update it as needed by calling the school nurse with new orders.

Student Name_____ **Age**_____ **Grade**_____

Emergency Contacts:

Parents/Guardians_____Phone_____

_____ Phone_____

Grandparent _____ Phone_____

Other _____ Phone_____

Physician: _____ Office Phone _____

Student's Personal Asthma Triggers:

____cats ____dogs ___pollen ____molds

_____aerosols ____dust/dust mites ____cold air ____chalk dust

_____chest infections ____humidity ____fumes ____smoke

____cleaning agents _____foods (please list below)

_____other_____

_____

What to do for an asthmatic episode:

Give rescue inhaler_____ **number of puffs**_____

Allow student to stop activity and rest. Remain calm to reduce student's anxiety. Do not leave student alone until improved. Contact parents if episodes are occurring frequently or episode does not relieve promptly. This could imply the student needs seen by the physician.

Get emergency help if the students has any of the following symptoms:

-No relief within 20 minutes of using rescue inhaler.

-Difficulty breathing or struggling to breath despite meds.

-Wheezing

-Difficulty talking

-Lips and fingernails are gray or bluish in color

-Peak flow less than _____L/min

What to do:

_____Give rescue inhaler again _____number of puffs

_____ Have someone call 911

_____Have someone notify parents

_____If no parent available to meet ambulance at ER, school staff is to accompany student and stay with student until parent/guardian arrives.

Any other special instructions:

_____

_____

Recommendation for Inhaler:

This recommendation is for the specific student named in this plan. This student may not permit any other student to have or use the prescribed medication.

Student Signature_____

Please indicate only one procedure to be followed:

_____**has demonstrated proper use and technique and should be allowed to carry and self-administer his/her inhaler by himself/herself.**

_____**will need assistance with his/her inhaler which should be kept by the teacher or school nurse but will be given immediately for asthma symptoms.**

Physician signature/ date_____

Parent signature/ date _____