the ACADEMY LEARN, LEAD & SERVE

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Permission to Administer Medication(s)

Student Name: _____ DOB: _____ Grade: _____

To Be Completed By Health Care Provider

Diagnoses _____

Medication Name	Dose	Route	Time	@ applicable boxes below
				AM_____ Bus FT SSA Self-Directed Self Admin-Self Carry
				AM_____ Bus FT SSA Self-Directed Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

AM	Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
Bus	Medication must be available on bus
FT	Medication is needed on field trips
SSA	Medication is needed school sponsored extra-curricular activities
Self-Directed	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.
Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature_____ **Date**_____ **Phone** _____

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature_____ **Date**_____ **Phone**_____

Self-Administer/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____ **Date** _____ **Phone** _____

Asthma Action Plan

Medical Record #.	Updated On:

[To be completed by health care provider]

Name _____ Date of Birth _____

Address _____ Emergency Contact/Phone _____

Health Care Provider Name _____ Phone _____ Fax _____

Asthma Severity: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Asthma Triggers: ❑ Colds ❑ Exercise ❑ Animals ❑ Dust ❑ Smoke ❑ Food ❑ Weather ❑ Other

If Feeling Well (Green Zone) — Take Every Day Long – Term Control Medicines

You have all of these:
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

If Not Feeling Well (Yellow Zone) — Take Every Day Medicines and (Add) these Quick-Relief Medicines

You have any of these:
- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick (Red Zone) — Take These Medicines and Get help from a Doctor NOW!

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow reading below:
_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or cry because of hard breathing or has passed out.

Make an appointment with your primary care provider within two days of an ER visit or hospitalization

Health Care Provider Signature _____ Date _____

Patient/Guardian Signature [I have read and understood these instructions] _____ Date _____

NYC Health

Citywide Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
Revised 10/13

WHITE - PATIENT COPY
PINK - SCHOOL/DAY CARE COPY
YELLOW - PROVIDER COPY

COPY FOR PATIENT

HPD X46041 09 08

Emergency Care Plan

ASTHMA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthma Triggers: _____ Best Peak Flow: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, Peak Flow of < _____.
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.
- Peak Flow of _____ or below.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

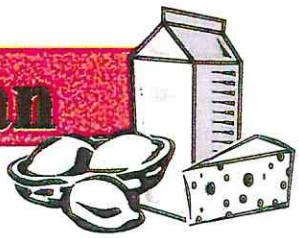
Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication as ordered: _____
Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.
Notify school nurse at _____ who will call parents/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

☑ Call 911 (Emergency Medical Services) and inform the that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.
☑ A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: _____ _____

Healthcare Provider: _____ Phone: _____

Emergency Care Plan



FOOD ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Allergen(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is give immediately.

Student Photo

STAFF MEMBERS INSTRUCTED:
❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT: Rinse contact area with water if appropriate

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms
Benadryl ordered: ❑ Yes ❑ No Give _____ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.
Epinephrine ordered: ❑ Yes ❑ No Special instructions: _____
_____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____
Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ❑ Medication available on bus ❑ Medication NOT available on bus ❑ Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ Age: _____

Allergies: _____

Asthma ☐ Yes *(high risk for severe reaction)* ☐ No

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

	Symptoms of Anaphylaxis
MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
**Some symptoms can be life-threatening. ACT FAST!*

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ Adrenaclick (0.15 mg) ☐ Adrenaclick (0.3 mg)

☐ Auvi-Q (0.15 mg) ☐ Auvi-Q (0.3 mg)

☐ EpiPen Jr (0.15 mg) ☐ EpiPen (0.3 mg)

Epinephrine Injection, USP Auto-injector- authorized generic
☐ (0.15 mg) ☐ (0.3 mg)

☐ Other (0.15 mg) ☐ Other (0.3 mg)

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ work_____ cell_____

Emergency contact #2: home_____ work_____ cell_____

Emergency contact #3: home_____ work_____ cell_____

Comments: _____

_____

_____

Doctor's Signature/Date/Phone Number

_____

Parent's Signature (for individuals under age 18 yrs)/Date

7/2013