Washington County Public Schools/ Meritus Health

HEALTH PROVIDER ORDER FOR ASTHMA MANAGEMENT

Student's Name:	Date of Birth:
School:	Grade:

☐ This order is valid for the current school year _____ (including summer)

☐ Start date: _____ End date: _____

HEALTH CARE PROVIDER TO COMPLETE

Diagnosis/Reason for Medication:	Allergies:

Green Zone	Control and Prevention	
	Name of Medication:	Route: INH
Signs/Symptoms • Breathing is good • No cough • No audible wheezing	☐ No control/prevention medications are needed at school ☐ Give _____ puffs with spacer (if available), daily at (specify time) _____ ☐ Give _____ puffs with spacer (if available) _____ mins before ☐ PE class ☐ Recess	
Yellow Zone	Continue green zone medication and <u>ADD rescue medications</u>	
Signs/Symptoms • Cough • Mild audible wheeze • Complains of chest tightness	Name of Medication:	Route INH
	☐ Give _____ puffs with spacer (if available) every _____ hours as needed for signs/symptoms. ☐ Give one dose via nebulizer every _____ hours as needed for signs/symptoms. ☐ Other: _____	
Red Zone	**DANGER CALL 911** and continue rescue medications as follows	
Signs/Symptoms • Can't speak in full sentences • Medicine is not helping • Breathing is hard and fast • Blue lips and/or fingernails • Nostrils flaring • Ribs showing	☐ No additional dosing, 911 only ☐ Give _____ puffs with spacer (if available) every 15 minutes for signs/symptoms until EMS arrives. ☐ Give one dose via nebulizer every 15 minutes for signs/symptoms until EMS arrives. ☐ Other: _____	

Potential Side Effects:

Student is competent to self-carry ☐ yes * ☐ no Student is competency to self-administer ☐ yes * ☐ no

*__Parent/guardian must complete the self-carry section on the back of this form__

Health Care Provider Name (print)		Provider Stamp
Address:		
Phone:	Fax:	
Health Care Provider Signature:		Date:

PARENT/GUARDIAN TO COMPLETE

I authorize School Health personnel and, when appropriate, trained school staff to administer the above-stated medication in accordance with school policies and Maryland State School Health Services Guidelines. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I have read the information on the back of this form and assume the responsibilities as stated therein. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (print):	Date:
Parent/Guardian Signature:	
Daytime Phone:	Other Phone:

Order reviewed by the School RN or LPN: _____ Date: _____

Washington County Public Schools/ Meritus Health

MEDICATION GUIDELINES

These guidelines enable school health staff to provide the best possible service to your child.

1. The health provider order forms must be completed and signed by the health care provider and the parent/guardian.
2. Prescription medication(s) must be in a container labeled by the pharmacist.
3. Over-the-counter medication(s) must be in the original sealed container.
4. The directions for administration listed on the prescription label must match the directions on the health provider order form.
5. Maryland law dictates that a medication is considered expired either 1 year after the medication was dispensed or on the expiration date indicated by the manufacturer; whichever comes first. Staff may not dispense expired medication.
6. The school nurse will call the prescriber as allowed by HIPAA and the Maryland Nurse Practice Act for questions related to the condition for which the order was prescribed.
7. To protect the safety of all students, an adult must transport all medications to and from school. Medications will not be sent home with the student.
8. The health provider order form must be reviewed and signed by the school RN or LPN before the medication can be administered. The school RN or LPN is allowed at least 2 school days to review and sign the order.
9. Students can not self-carry routine medications for self-administration during the school day. Only prescribed medications used to treat medical emergencies will be considered for self-carry.

PARENT/GUARDIAN TO COMPLETE
Self-carry Conditions • Students that self-carry and/or self-administer emergency medications must first have a written order from a licensed health care provider and written approval from the parent/guardian. • Once the written approvals are on file in the health office, the school nurse will conduct a nursing assessment to determine if the request to self-carry and/or self- administer can be safely executed. This includes an assessment of the student's ability to safely possess and self-administer the medication. • If approved, the school nurse will create a written agreement that details the expectations of all parties. The agreement must be signed by the student, school nurse, parent/guardian, and the principal. • The school nurse will evaluate and reassess the student's competency to self-carry and/or self-administer his/her medication at specified intervals throughout the school year. • If the nurse observes the student without his/her medication, or handling the medication in an unsafe manner, the student's ability to self-carry will be discontinued until the management plan is re-evaluated for safety. • The student may be subject to disciplinary actions if he/she fails to use and store the medication in a safe manner.
I give permission for my child to self-carry and/or self-administer his/her inhaler during the school day and during school-sponsored activities. I have read and agree to the self-carry conditions listed above.
Parent/Guardian Name (print):
Parent/Guardian Signature: Date: