Meritus Health Washington County Public Schools

PHYSICIAN MEDICATION ORDER FOR THE MANAGEMENT OF ASTHMA

Name:	Date of Birth:	Order Valid for School Year _____(including summer):
Parent/Guardian:	Parent's phone number:	
Additional Emergency Contact:	Contact phone number:	

Health Care Provider to Complete

Asthma Severity Classification	Asthma Triggers (Things that make your asthma worse)
□ Mild Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent	□ Colds □ Smoke □ Exercise □ Pollen □ Dust □ Animals _____ □ Strong Odors □ Mold/moisture □ Pest (rodents, cockroaches) □ Season (check) □ Fall □ Winter □ Spring □ Summer □ Other: _____

Green Zone: Go! – Take these CONTROL (PREVENTION) Medicines at School

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

□ **No control medicines are required**

□ _____, **take** ___ **puff(s) with spacer** daily at _____
Inhaled corticosteroid or inhaled corticosteroid/long-acting ß-agonist/Dose *(specify time)*

□ **Other**: _____

For asthma with exercise, ADD:

□ _____, _____ **puffs with spacer** ____ **min. before** ☐ **PE** ☐ **Recess**
Fast-acting inhaled ß-agonist/Dose

Yellow Zone: Caution! – Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- Cough or mild audible wheeze
- Tight chest

□ _____, _____ **puffs with spacer every** _____ **hours as needed**
Fast-acting inhaled ß-agonist/Dose

□ _____, _____ **nebulizer treatment (s) every** ____ **hours as needed**
Fast-acting inhaled ß-agonist/Dose

□ **Other** _____

Red Zone: DANGER! – Continue CONTROL & RESCUE Medicines and CALL 911

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic

□ **Call 911 only**

□ _____, _____ **puffs with spacer every 15 minutes**
Fast-acting inhaled ß-agonist/Dose

□ _____, _____ **nebulizer treatment (s) every 15 minutes**
Fast-acting inhaled ß-agonist/Dose

□ **Other** _____

☐ **Student is competent to self-carry/self-administer inhaler**	**Date:**
Health Care Provider Name (print)	**Phone:**
Health Care Provider Signature:	**Fax:**

Parent/Guardian to Complete

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. I release Meritus Health, the Washington County Board of Education, and their employees from any claim or liability for administering prescribed medication to this student. I have read the information on the back of this form and assume the responsibilities as stated on this form. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:	**Date:**

Order reviewed by the School Health RN_____ Date:_____

MEDICATION GUIDELINES

The following medication guidelines are used in Washington County Public Schools. These guidelines enable the school health staff to provide the best possible service to your child.

1. In order for medication to be given at school, the medication must be accompanied by a properly completed *Physician Medication Order form for the Management of Asthma* form.
2. The school nurse will call the prescriber as allowed by HIPAA if a question arises about child and/or child's medication.
3. Prescription medication(s) must be in a container labeled by the pharmacist with the student's name, prescriber's name, name of medication, dosage, route, directions for administration, conditions for storage, prescription date and expiration date. Maryland law allows prescription medication to be used only for 1 year beyond date of issue or expiration date indicated on the medication—whichever comes first.
4. An adult must bring the medication to school. No medication will be sent home with a student.
5. All medication must be picked up by an adult at the end of the school year. NO medication will be sent home with your child.
6. If the health care provider indicates that the student is competent to self-administer and/or self-carry, the school registered nurse shall then certify that the student possesses the skills and maturity necessary to self-administer and/or self-carry in the school setting.
7. If the health care provider and school registered nurse both determine that the student is capable to self-carry and/or self-administer, the principal and school registered nurse shall establish procedures for the student to self-carry and/or self-administer. The principal, school registered nurse, parent/guardian, student (if appropriate), and the health care provider may be asked to provide input into the self-carry/self-administer procedures that are most appropriate for the student. The principal and/or school registered nurse may revoke the authority of a student to self-carry medication if the student fails to follow the proper procedures, rules, and regulations for self-carry/self-administration, including if the student endangers anyone through the misuse of the medication.
8. The *Physician Medication Order for Management of Known Anaphylaxis* form must be reviewed and signed by the school RN before medication administration can begin. The school RN is allowed at least 2 school days to review and sign the order.

Self-Carry/Self-Administration of Emergency Medication Contract

This section must be completed for students to self-carry/self-administer prescribed emergency medication.

1. Student has demonstrated the purpose, appropriate method, and time to administer the inhaler to the nurse.
2. Student agrees to never share the medication with another student.
3. Student will report each administration of the inhaler to the health office by the end of each week.
4. If the student uses his inhaler and there is no improvement of symptoms, student must report to health office immediately.

The student may be subject to disciplinary action if he/she does not carry/use the medication in a safe and proper manner.

Student Signature:	Date:
School Nurse Signature:	Date:
School Administrator Signature:	Date:

I give my permission for my child (name) _____to carry the inhaler as prescribed by the health care provider. I understand that he/she must follow the rules listed above. I will notify the health office of any changes to my child's medication or medical condition.

Parent/Guardian Name (print):

Parent/Guardian Signature:	Date: