*COMPLETED BY PCP *

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REQUEST FOR ADMINISTRATION OF MEDICATION

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/ treatment. A separate request is needed for each medication.

*PCP READ THIS *

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.
DATE OF BIRTH	SCHOOL	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDJCATION:	DOSE:
TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:
DATE BEGIN:	DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS: _____

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN: _____

RESTRICTION ON ACTIVITY: YES ☐ NO ☐

IF YES, DESCRIBE: _____

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: _____

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

MED-1 (Rev. 6/2018 - COMM. CODE 1602445400

*COMPLETED BY PARENT *

I authorize licensed school personnel to administer the indicated medication as prescribed by my child's health care provider, whose signature appears on this form

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

*COMPLETED BY NURSE *

In accordance with school district procedure:

- I have assessed the student and s/he has demonstrated competency to self-administer medications.
  YES____NO_____
- The administration of this medication was approved on:

_____

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

*COMPLETED BY PCP *

TO THE PHYSICIAN:
Your patient has requested that medication be administered in school. Ideally, the administration of medication should take place at home. However, for students who require medication during the school day in order to function in the classroom, School District Policy does permit licensed school staff to administer medication. In some cases, students may self-administer their medication.

IF YOUR PATIENT'S MEDICATION CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE· A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT.

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you.

School Health Services

DEAR PARENT/GUARDIAN:

Some children need the administration of medication in order to function in the classroom. Ideally, this should take place at home. If your child's medication schedule cannot be altered and administered at home, you can request the medication to be given in school by seeing the school nurse.

Once the School Nurse has approved the request, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

This procedure must be repeated each school year and/or each time there is a change in dosage.

Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school, will be destroyed/discarded.

If you have any questions on this procedure, please contact the school nurse.

. Thank you.

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ (Date) To _____ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

_____

_____

I give permission to administer medication to my child as stated above.

_____ (Parent Signature) _____ (Date)

FACILITY STAFF COMPLETE THIS SECTION				
Date Administered (mm/dd/yyyy)	**Time Administered (a.m. / p.m.)**	**Amount of Medication Administered**	**Comments/Reactions**	**Staff Initials**

This information is confidential and may not be shared or released without the parent's written permission.

****MUST BE COMPLETED MONTHLY**

CY 862 10/04

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Pennsylvania Chapter

Asthma Action Plan for a Young Child

Child's Name_____ Date of Birth _____

Address_____ Home Phone (_____) _____

City_____State _____ Zip code _____

Diagnosis _____ Other Medical Conditions _____

❒Food allergy – Specify _____

❒Other allergies-Specify _____

Emergency Information

Parent Contact _____ Preferred Phone # _____ Other Phone # _____

Address_____ City_____ State _____ Zip _____

Physician Name_____ Phone_____

Address_____ City_____ State _____ Zip _____

Emergency Contact Name_____ Phone_____

Environmental Information

Pets in your home? ❒ No ❒Yes Specify _____

Smokers in family? ❒ No ❒Yes Number _____

Mother ❒ No ❒Yes Father ❒ No ❒Yes Other ❒ No ❒Yes Specify _____

Persons other than parents who care for your child _____ Do they smoke? ❒No ❒Yes

Exposure to smokers worsens asthma for children. Contact your doctor for tips to quit or use the Center for Disease Control website, www.cdc.gov/tobacco/campaign/tips/quit-smoking/ or 1-800-QUIT-NOW.

Asthma Triggers

❒Cold/Virus ❒Dust ❒Mold ❒Pollen/grass ❒Pets ❒Exercise ❒Weather ❒Other _____

Medication(s) Given at Home:

_____

_____

_____

_____

Child's Name _____

Quick Relief Medication to be given in child care if symptoms listed below occur:

If a child is breathing HEAVY AND FAST and CAN NOT TALK WELL or LIPS OR FINGERNAILS are BLUE OR GRAY-**CALL 911** AND PARENTS IMMEDIATELY.

Symptoms:

New wheezing is heard (a noise heard when breathing out)
New frequent cough with or without activity
Chest retraction (sucking in at the base of the neck, between or below the ribs)
Shortness of breath or rapid breathing
Complaint of chest tightness
Additional warning signs:
_____
_____

- Remove the child from any asthma triggers.
- Give medication listed below.

Medications

❒ **Inhaler** with a spacer and mask (preferred for young children) or mouthpiece: Ask the health care provider about use of a spacer and inhaler in child care for easier and more effective delivery of inhaled asthma medication.

☐ Albuterol Metered Dose Inhaler
(Pro-air, Proventil or Ventolin):
2 puffs (wait one minute between puffs),
may repeat once in 4 hours.

☐ Xopenex HFA Inhaler:
2 puffs (wait one minute between puffs),
may repeat once in 4 hours.

☐ Other: _____
_____

❒ **Nebulizer:**

☐ Albuterol _____1.25mg _____ 2.5mg:
1 unit nebulized, may repeat once in 4 hours

☐ Xopenex (Levalbuterol)
_____0.31 mg _____0.63mg _____1.25 mg:
1 unit nebulized, may repeat once in 4 hours

☐ Other: _____
_____

- Call the parents to let them know you have given the medication.
- Call the parents or emergency contact for immediate pick-up if the child does not improve within 20 minutes.
- **CALL 911 i**f symptoms worsen and parents or emergency contact cannot be reached.
- If quick-relief medication is used more than two days in one week, the parent should talk with the child's health care provider about the need for additional medication.
- Early education staff have received in-person instruction for correct use of specific equipment needed: Inhaler with spacer and mask or nebulizer. Yes_____ No_____

I give permission to _____ (name of health care provider/practice) to share information about how to care for my child's asthma with _____ (name of child care provider).
I have read and understand this asthma action plan.

Parent's signature _____ Date _____

Physician signature _____ Date _____

Child care provider signature _____ Date _____

This is one of many options for an Asthma Action Plan for health care providers to share information with child care providers. This plan is meant for children who need medication intermittently in child care. Another Asthma Action Plan is from the National Heart, Lung and Blood Institute and available at www.nhlbi.nih.gov