

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2025-2026

Student Last Name First Name Middle Initial

Date of Birth ____ / ____ / ____
M M D D Y Y Y Y

☐ Male
☐ Female

Grade/Class ____

School Name

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis

☐ Asthma

Control (see NAEPP Guidelines)

☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

Severity (see NAEPP Guidelines)

☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation ☐ Y ☐ N ☐ U
History of life-threatening asthma (loss of consciousness or hypoxic seizure) ☐ Y ☐ N ☐ U
History of asthma-related PICU admissions (ever) ☐ Y ☐ N ☐ U
Received oral steroids within past 12 months ☐ Y ☐ N ☐ U ____ times last : ____ / ____ / ____
History of asthma-related ER visits within past 12 months ☐ Y ☐ N ☐ U ____ times
History of asthma-related hospitalizations within past 12 months ☐ Y ☐ N ☐ U ____ times
History of food allergy or eczema, specify: ____ ☐ Y ☐ N ☐ U

Student Skill Level (Select the most appropriate option)

- ☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision
☐ Independent Student: student is self-carry / self-administer

Practitioner
Initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Home Medications (Include over the counter)

☐ Reliever ____
☐ Controller ____
☐ Other ____

Quick Relief In-School Medication (Select ONE)

☐ Albuterol MDI

[Ventolin® MDI can be provided by school for shared usage (plus individual spacer):

- ☐ MDI w/ spacer
☐ DPI

☐ Other: Name: ____ Strength: ____
Dose: ____ Route: ____ Time Interval: ☐ ____ hrs

In-School Instructions (Check all that apply)

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress*: Call 911 and give 6 puffs/1 AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare (Within 5 days):**
2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration

(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ Fluticasone MDI

[Flovent® 110 mcg MDI can be provided by school for shared usage]:

- ☐ MDI w/ spacer
☐ DPI

☐ Other: Name: ____ Strength: ____
Dose: ____ Route: ____ Time Interval: ☐ ____ hrs

☐ **Standing Daily Dose:**

____ puffs/1AMP ONCE a day at ____ AM

Special Instructions:

Health Care Practitioner (Please Print Name)

Last First

Address

Tel. (____) ____ - ____ - ____

Signature

Fax (____) ____ - ____ - ____

Date ____ / ____ / ____

NPI # ____ - ____ - ____

Email Address

NYS License # (Required)

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

PARENTS MUST SIGN PAGE 2 ➔

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PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
 - o I must give the school nurse my child's medicine.
 - o All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
 - Prescription medicine must have the original pharmacy label on the box or bottle.
 - o I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
 - o The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name	First	Date of Birth ____ / ____ / ____
Parent/Guardian Print Name:		Signature:
Date Signed ____ / ____ / ____		Cell Phone:
Other Phone:		Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ____ / ____ / ____