

# ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2024-2025

Student Last Name _____	First Name _____	Middle Initial _____	Date of Birth ____/____/____ <small>M M D D Y Y Y Y</small>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Grade/Class _____				
School Name _____				

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

<b>Diagnosis</b> <input type="checkbox"/> Asthma	<b>Control</b> (see NAEPP Guidelines) <input type="checkbox"/> Well Controlled <input type="checkbox"/> Not Controlled / Poorly Controlled <input type="checkbox"/> Unknown	<b>Severity</b> (see NAEPP Guidelines) <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent
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### Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U
History of asthma-related PICU admissions (ever)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U
Received oral steroids within past 12 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U _____ times last : ____/____/____
History of asthma-related ER visits within past 12 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U _____ times
History of asthma-related hospitalizations within past 12 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U _____ times
History of food allergy or eczema, specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> 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)		Signature		Date ____/____/____	
Last	First				
Address		Tel. (____) _____	Fax (____) _____	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 →**

**ASTHMA MEDICATION ADMINISTRATION FORM 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.

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

**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.

<b>Parent/Guardian Print Name:</b>	<b>Signature:</b>
	<b>Date Signed</b> ___ / ___ / ____