RIVER MILL ACADEMY
Authorization of Medication For A Student At School

Date Received _____

Please Check: Prescription _____Non-Prescription _____

NAME OF CHILD _____ BIRTHDATE _____

SCHOOL _____ DATE _____

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours, at school-sponsored activities, while in transit to or from school or school-sponsored events.

Medication _____

Medical Condition requiring medication_____

Circle medication to be given or applied: tablet ointment capsule inhalation liquid injection

Dosage (amount to be given): _____

How often or at what time: _____

Side effects: _____

FOR CASES WHERE SELF-MEDICATION OF EMERGENCY MEDICATION IS NECESSARY: (Prescriber's initials required.)
Student may carry and self-administer emergency medication. Yes ☐ No☐ Student has been instructed, understands, and demonstrates the skill level necessary to use medication and any device necessary to administer medication:

PRESCRIBERS INITIALS: _____

This student has asthma_____. This student has allergy(s) that could result in anaphylactic shock_____. Other_____
If an emergency occurs during the school day or if the student becomes ill, school officials are to:
1. Contact me at my office at _____2. Call 911 if _____ 3. Other_____

PARENT'S PERMISSION FOR CHILD TO SELF-MEDICATE (NOTE: Additional parent signature required)
I give my permission for my child (named above) to possess and self-administer the medication prescribed above during school hours. I hereby release the River Mill Academy School Board of Directors and their agents and employees from all liability that may result from my child possessing or taking the prescribed medication.
(Student must follow responsibilities regarding medication outlined in student handbook.)

_____
Signature of Parent or Guardian

Prescriber's Name _____
Prescriber's Signature _____
Drug Enforcement Administration No _____
Prescriber's Telephone Number _____

PARENT'S PERMISSION-Parent read and sign below:
I hereby give my permission for my child (named above) to receive the medication prescribed above during school hours, at school-sponsored activities, while in transit to or from school or school sponsored events. A practitioner authorized to prescribe medication has prescribed this medication. I will furnish this medication in a properly labeled container. I hereby release the River Mill Academy School Board of Directors and their agents and employees from any and all liability that may result from my child taking the prescribed medication. I agree to allow my child's health care provider and school personnel to discuss information on this form.

_____
Signature of Parent or Guardian

_____
Telephone No. Date

For self-administered medication authorized by the prescriber, the student demonstrates to the school nurse the skill level necessary to use medication and any device used to administer medication.

Reviewed by: _____
Signature of School System Nurse Date

_____
Name and Title of Person to Administer Drug

Approved by: _____
Signature of Principal Date

Rev. 5/12 medauth.doc

Note: Asthma Action Plan is on back of form for use with students with asthma.

_____'s Asthma Action Plan

Patient's Name

Personal Best Peak Flow Meter Score: _____ Date:_____

Category of severity: (check one) __ Mild Intermittent __ Mild Persistent __ Moderate Persistent __ Severe Persistent

Other Important Instructions:

1. ***No smoking in your home or car.***
2. Remove known *triggers* from your child's environment: _____
3. Other: _____

GREEN

Your Peak Flow is greater than _____
(80% of your personal best peak flow number)

You:

- sleep through the night without coughing or wheezing
- have no early warning signs of an asthma flare-up & can do usual activities

Take Long-Term Control medications:

- _____
- _____
- _____
- _____

Continue to avoid triggers.

Take quick-relief medicines 15 minutes before exercise.

- _____

Physician:

_____

Telephone Number:

_____

Student may carry and self-administer medication_____

YELLOW

Your Peak Flow is between _____ and _____
(50%-80% of your personal best peak flow number)

You may:

- be coughing or wheezing at night or at school
- have early warning signs of a flare-up
- have trouble doing your usual activities (school, play, work, exercise)

Take quick-relief medicines:

- _____
- _____
- _____

Adjust Long-Term Control medicines as follows until back in Green Zone:

- _____
- _____
- _____

Call your doctor if:

- you stay in the Yellow Zone for more than ___ hours
- your symptoms are getting worse
- you use quick-relief medicine more than every 4 hours

RED

Your Peak Flow is less than _____
(50% of your personal best peak flow number)

You may:

- be coughing, short of breath, wheezing
- suck in skin between ribs, above your breastbone and collarbone when breathing
- have trouble walking or talking

Emergency Medicine Plan:

- _____
- _____
- _____
- _____

Call your doctor or emergency room and ask what to do.

Call 911 if no improvement and:

- your nails or lips are blue
- you have trouble walking or talking
- you cannot stop coughing

A project of:

HEALTHY ALAMANCE

Child Asthma Coalition