THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REQUEST FOR ADMINISTRATION OF ASTHMA 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.

NAME OF PATIENT/STUDENT	ROOM/BOOK NO.
DATE OF BIRTH SCHOOL	PID
DIAGNOSIS:	
REASON MEDICATION MUST BE GIVEN IN SCHOOL:	
NAME OF MEDICATION:	DOSE:
TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:
DATE BEGIN:	DATE END:
INSTRUCTION FOR ADMINISTRATION/UTILIZATION:	
CONTRAINDICATIONS:	

SIDEEFFECTS:__________________________

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

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 ______________

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 ____________________

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

Steps to take during an asthma episode:

- Remove student from any obvious trigger listed above.
- **DO NOT** leave student alone.
- Sit student comfortably leaning forward, **DO NOT** insist that they lay down.
- Check student's peak flow reading (if available)
- Give initial treatment of emergency school asthma medication and allow rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler.
- Check for decreased symptoms (or increased peak flow reading)
- Contact parent/guardian to make them aware of asthma episode and effectiveness of treatment.
- If symptoms **DO NOT** decrease after initial treatment with medication, the situation can quickly become an asthma emergency. **CALL 9-1-1 if condition worsens.**

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 medications. 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 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.

The school is not responsible for ensuring the medication is taken. The district and its employees are relieved of responsibility for the benefits or consequences of the prescribed medication.

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.