Gateway Community Charters
Asthma Inhaler Medication Order and Care Plan

This order is valid only for school year (current) _____ including summer session, unless revoked by the parent, physician, or school nurse if the student fails to comply.

Student Name_____ Date_____

School: _____ Grade:_____

This form must be completed fully in order for a student to use/self-carry administer his/her prescribed asthma inhaler while at school, school-sponsored activities, or in transit to and from school or school-sponsored activities.

Requirements

□□Section 1 must be completed by the prescribing provider
□□Section 2 must be completed and signed by a parent or guardian.
□□Section 3 To Carry: must be completed by the student & verified by the School Nurse.
□□The student must comply with all instructions and regulations associated with carrying and administering the inhaler.
□□Prescription medication must be in an original container labeled by the pharmacist or prescriber.

Section 1 – Prescriber Authorization

Name of Student: _____ Date of Birth: _____

Diagnosis:_____ Medication Name: _____

Dose: _____ Route: _____ Time/Frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: □ None expected □ Specify: _____

Extreme side effects do_____

Please initial next to each statement:

_____ I confirm this student has been fully instructed on the use of his/her medication
_____ I confirm this student is capable of carrying/self-administering prescribed medication
_____ I **DO NOT** recommend this student be allowed to self-carry and administer the prescribed medication.

Prescriber Name/Title: ____________________ Telephone: _____________

Prescriber Signature: ________________________________ Date: ________

Seek emergency medical care if this student experiences any of the following:

Call 9-1-1

- o No improvement 15-20 minutes after initial treatment with medication
- o Chest and neck pulled in with breathing
- o Hunched over while breathing
- o Struggling to breathe
- o Trouble walking or talking
- o Stops playing/cannot start activity again
- o Lips/fingernails turn gray/blue
- o Stops breathing Start CPR

Comments and special instructions: ____
____

* *

Section II Parent

My Signature below Verifies that

I am the parent of legal guardian of the student named above and authorize my child to receive the medication as ordered above and authorize the school nurse to communicate with appropriate school staff regarding this medication order/care plan.

I release the school district and school personnel from civil liability resulting from my child taking medication in this manner.

Parent/Guardian Signature__________________________________ Date__________

* *

Section III – TO CARRY-Student/School Nurse Certification

Please initial next to each statement:

_____ I agree to use my inhaler as prescribed above. I understand my asthma triggers, symptoms, and treatment plan (verbalize to School Nurse).

_____ I understand the correct technique for administering my inhaler (demonstrated).

_____ I agree to keep my inhaler with me at school at all times.

_____ I understand that it is important for me to let an adult in the school office, as well as my parents, know if I am having more difficulty than usual with my asthma.

_____ I agree to never share my inhaler with anyone.

Student Signature: ____________________________________ Date: ____________

School Nurse Signature: ________________________________ Date: ____________