White River School District No. 416
240 North A Street * PO Box 2050 * BUCKLEY WA 98321 * 360-829-0600

HEALTH CARE PROVIDER MEDICATION REQUEST & TREATMENT PLAN FOR ASTHMA

Student Name: ______________________ Has asthma and may need to take medication at school.

SCHOOL (please check school of attendance):

	School	Fax		School	Fax
☐	White River High School	Fax; 360-829-3351	☐	Glacier Middle School	Fax; 360-829-3391
☐	Elk Ridge Elementary	Fax; 360-829-3392	☐	Foothills Elementary	Fax; 360-829-3381
☐	Mountain Meadow Elementary	Fax; 360-829-3388	☐	Wilkeson Elementary	Fax; 360-829-3386

This section to be filled out by Physician

The treatment plan for managing asthma at school is as follows: (check all that apply)

Drug & Dosage Form	Dose, Time & Mode of Administration
☐ Albuterol Inhaler ☐ with spacer	☐ 2 (or _____) puffs by mouth 5-20 minutes prior to exercise ☐ 2 (or _____) puffs by mouth every 3-4 hours as needed for symptoms ☐ If no relief after treatment, call 911 ☐ Other: _____
☐ Albuterol via Nebulizer ☐ Levalbuteral via Nebulizer ☐ mouthpiece ☐ mask	☐ 1 unit dose every _____ hours as needed for symptoms ☐ Other: _____
☐ Other:	

- ☐ Use peak flow meter per attached directions.
- ☐ Student is to inform school nurse if using albuterol inhaler more than 4 x/day or if asthma causes awakening at night.
- ☐ Other: _____
- ☐ Student has been instructed in use of device needed to administer medication.
- ☐ Student has demonstrated the skill level necessary to use the medication appropriately.
- ☐ Student recognizes symptoms of asthma and will seek assistance if needed.
- ☐ Student may carry and self-administer the medication ordered above.

______________________ Health Care Provider's Signature | ______________ Telephone | ______________ FAX

______________________ Health Care Provider's Printed Name or Stamp | ______________ Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, (Name of Child) ______________________ or allow my child to carry and self-administer as indicated above, the medication prescribed by (name of health care provider) ______________________ for the school year ending June ______________
The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, <u>I will collect the medication from the school or understand that it will be destroyed</u>. I am the parent or the legal guardian of the child named.

______________________ Parent/Guardian Signature | ______________ Home Phone | ______________ Work Phone

______________________ Date | ______________ Cell Phone | ______________ Other

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above.

School Nurse Signature:		Date:	