Alamance-Burlington School System
Authorization of Medication For A Student At School

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

Dosage (amount to be given): ____

How often or at what time: ____

Side effects: ____

No injection will be given except for diabetic care or extreme emergency, such as severe allergy.

FOR CASES WHERE SELF-MEDICATION OF EMERGENCY MEDICATION IS NECESSARY: (Prescriber's initials required.)
Student may carry and self-administer 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 Alamance-Burlington School Board of Education 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 Alamance-Burlington School System Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

____
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

____
Name and Title of Person to Administer Drug

Approved by: ________________________________
Signature of Principal Date

Rev. 2/06 medauth.doc

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

In compliance with federal laws, the Alamance-Burlington School System administers all educational programs, employment activities and admissions without discrimination because of race, religion, national or ethnic origin, color, age, military service, disability, or gender, except where exemption is appropriate and allowed by law. Inquiries or complaints should be directed to the Director of Student Services, Alamance-Burlington School System, 1712 Vaughn Road, Burlington, NC 27217 336.570.6060.

______________________'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** __________

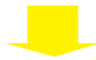
(50%-80% of your personal best peak flow number)

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