MEDICATION ORDER

For online forms:  http://sbo.nn.k12.va.us/healthservices/medications.html

It is best if students can take medication at home. When this is not possible, Newport News Public Schools will cooperate in the administration of medication during school hours. These procedure must be followed for all prescription medications, all over the counter drugs & supplements and herbal remedies.

1. Written orders, from a physician, detailing the name of the drug, dosage and time interval medication is to be taken must be on file. Medication ordered 3 times a day or less cannot be given without a specific time. Orders should specify a time since lunch time can be anywhere from 10:30 am to 1:00 pm.

2. The signature of parent or guardian requesting that the school division comply with the physician’s order is required. Medication will be given by the school nurse or school personnel designated by the principal.

3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy or physician. Bring only that amount of medication to be taken during school hours. Extra medication must be picked up by a parent. Advil, Tylenol, and other over the counter medicines must be handled the same as prescription drugs and be in a new unopened container. Expired drugs will not be given.

Please complete and sign this form (Medical Providers are asked to complete the Asthma Action Plan on the reverse side of this form for students with Asthma):

Name of Child:___________________________________________________________
Diagnosis:_______________________________________________________________
Date of Order:____________________________________________________________
Name of Medication:_______________________________________________________
Dose:___________________________________________________________________
Duration of Order:_________________________________________________________
(Duration cannot exceed current school year.)
Comments:_______________________________________________________________

Physician Signature:__________________________ Print:_________________________
Phone Number:______________________________

I request that the school give the above medications as ordered by the physician. I give permission for the school nurse to contact the physician if indicated to carry out this order.

__________________________________  ______________________________
School Student Attends               Parent or Guardian

R-6/12
Virginia Asthma Action Plan

School Division:

Name
Date of Birth

Health Care Provider
Provider’s Phone #
Fax #

Parent/Guardian
Parent/Guardian Phone
Parent/Guardian Email:

Effective Dates
/ / to / /

Last flu shot
/ / / 

Additional Emergency Contact
Contact Phone
Contact Email

Asthma Severity: ☐ Intermittent or Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Triggers (Things that make your asthma worse)
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals: __________________ ☐ Strong odors ☐ Mold/moisture ☐ Stress/Emotions
☐ Exercise ☐ Acid reflux ☐ Pests (rodents, cockroaches) ☐ Season (circle): Fall, Winter, Spring, Summer ☐ Other:

Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

You have ALL of these:
• Breathing is easy
• No cough or wheeze
• Can work and play
• Can sleep all night

Peak flow: ________ to ________
(More than 80% of Personal Best)

Personal best peak flow: ________

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.
☐ Dulera __________ Symbicort __________ Advair ________ , ___ puff (s) ___ times a day
☐ Combination medications: inhaled corticosteroid with long-acting β-agonist
☐ Alvesco __________ Asmanex ________ Azmacort ________ Flovent ________ Pulmicort ________ QVAR ______
☐ Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist
☐ ______ puff (s) MDI ___ times a day Or ______ nebulous treatment (s) ___ times a day

☐ Singular or __________________________, take ___ by mouth once daily at bedtime
☐ Leukotriene antagonist

For asthma with exercise, ADD: ☐ Albuterol or _____________________, ___ puffs with spacer 15 minutes before exercise

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have ANY of these:
• Cough or mild wheeze
• First sign of cold
• Tight chest
• Problems sleeping, working, or playing

Peak flow: ________ to ________

☐ Albuterol or _____________________, ___ puffs with spacer every ___ hours as needed
☐ Inhaled β-agonist

☐ Albuterol or _____________________, one nebulous treatment (s) every ___ hours as needed
☐ Inhaled β-agonist

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn’t work.

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have ANY of these:
• Can’t talk, eat, or walk well
• Medicine is not helping
• Breathing hard and fast
• Blue lips and fingernails
• Tired or lethargic
• Ribs show

Peak flow: < ________
(Less than 60% of Personal Best)

☐ Albuterol or _____________________, ___ puffs with spacer every 15 minutes, for THREE treatments
☐ Inhaled β-agonist

☐ Albuterol or _____________________, one nebulous treatment every 15 minutes, for THREE treatments
☐ Inhaled β-agonist

Call your doctor while administering the treatments.

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY:
☐ Student instructed in proper use of their asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.
☐ Student is to notify designated school health officials after using inhaler at school.
☐ Student needs supervision or assistance to use inhaler.
☐ Student should NOT carry inhaler while at school.

School: __________________________ Date: __________

MD/NP/PA SIGNATURE: __________________________ Date: __________

Blank copies of this form may be reproduced or downloaded from www.virginiaasthma.org

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/12

Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership