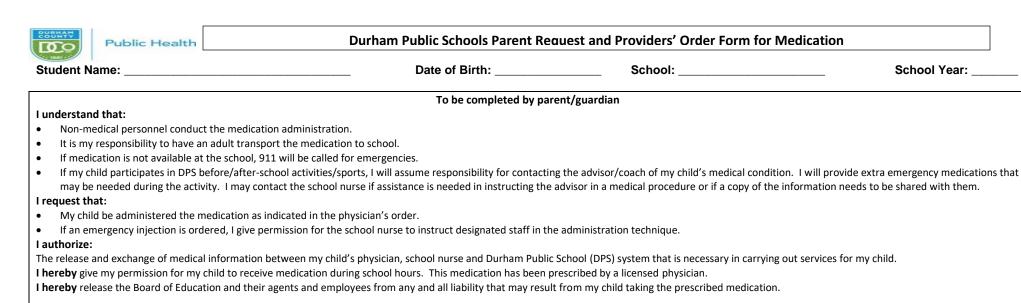


Durham Public Schools Parent Request and Providers' Order Form for Medication

Studer	it Name:		Date of Birth:	School:	School Year:
	Diagnosis	Medication Name Right Medication	Dosage Right Amount	How to Give Right Route	When to Give Right Time
DAILY□ PRN □	Diagnosis				
Allergy	List of Allergens:	☐ Diphenhydramine (Benadryl) ☐ Other	Dose	☐ By Mouth ☐ Other	☐ Upon Exposure ☐ Mild Reaction
		☐ Epinephrine Auto-Injector	□ 0.15 mg □ 0.3 mg	Intramuscular (IM) Injection	☐ Upon Exposure ☐ Severe Reaction ☐ If provided, repeat does after minutes if symptoms continue
Asthma	Green Zone Exercise Induced	☐ Albuterol ☐ Other	☐ 2 puffs ☐ 1 ampule/vial ☐ Other	☐ Inhaled (use spacer if provided) ☐ Nebulizer	□ DAILY before exercise□ AS NEEDED before exercise□ Other
	Yellow Zone	☐ Albuterol ☐ Other	□ 2 puffs □ 4 puffs □ 1 ampule/vial □ Other	☐ Inhaled (use spacer if provided) ☐ Nebulizer	☐ Every 4 hours as needed ☐ Other
	Red Zone CALL 911	☐ Albuterol ☐ Other	CALL 911 4 puffs 1 ampule/vial Other	☐ Inhaled (use spacer if provided) ☐ Nebulizer	For Emergency Symptoms
	Other Asthma Medications (EX: Symbicort, Dulera, etc.)	□	☐ Exercise: puff(s ☐ Yellow Zone puff(s) Call parent/guard	numbers of puffs and minutes no ranges) inhaled before exercise as needed to prevent s inhaled every minutes for cough/wheeze/s dian if symptoms have not improved after p puff(s) inhaled every minutes up to	symptoms shortness of breath, up to puffs ouffs.
	Diabetes	☐ Glucagon ☐ GVoke ☐ Baqsimi ☐ Other	□ Dose	☐ Subcutaneous SQ ☐ Intramuscular IM ☐ Nasal Spray ☐ Other	If student becomes unconscious
	Seizure	☐ Diastat ☐ Valtoco ☐ Nayzilam ☐ Other	□ Dose	☐ Rectal Gel ☐ Nasal Spray ☐ Other	☐ Seizure Onset ☐ After 5 minutes ☐ After minutes — Other
Physician's Printed Name:		Physician's Tel:	Date: MD Si	tomp	
Physician's Signature:		Fax:	Date: MD Si Nurse Review/Signature/Date:	апр.	



Student Self-Carry and Self-Administration of Medication

Parent/Guardian Print Name: ______ Parent/Guardian Signature: _____ DATE: _____ Phone:

To be completed by Physician	To be completed by Parent/Guardian:	
The student must have the medication(s) listed on the reverse side of this form during the school day or	I request and give permission for my child to carry and give the medication listed on the reverse side	
at school sponsored events in order to function. Adult Supervision is NOT needed. The student has	during the school day, at school-sponsored activities or while in transit to or from school. Adult	
been instructed in the treatment plan and self-administration of the listed medication(s) and has	supervision is not needed.	
demonstrated the skill level necessary to self-administer medications for:	I understand that:	
☐ Asthma ☐ Severe Allergy ☐ Insulin ☐ Other For Epinephrine Auto Injector Only:	 I shall provide the school back-up medication (in addition to what student will carry) that kept at school. 	t shall be
In the event the student is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector, the school nurse will train designated school staff to administer the Epinephrine Auto	My child will be required to demonstrate the skill level necessary to use the self-administered emergency medication to school staff trained by the school nurse.	
Injector and call 911.	My child will be subject to disciplinary action if medication is used in any other manner than	
11/30001 41/4 04/10221	prescribed.	iiaii
Physician Printed Name:	For Epinephrine Auto Injector Only:	
	In the event the student is experiencing respiratory difficulty and is unable to administer the	
Physician Signature: Date:	Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the	
	Epinephrine Auto Injector and call 911. I have observed my child demonstrate the necessary	
To be completed by Student at School:	to implement the care plan prescribed by his/her health care provider.	
☐ I have demonstrated use of my medication for the school staff listed	Parent/Guardian Signature: Date:	
☐ I plan to keep my medication and equipment with me at school.	- di city dan didi digitati ci	
☐ I will use my medication as advised by my physician.	To be completed by School Nurse:	
☐ I will not allow any other person to use my medication.	I have observed the student indicated above verbalize and demonstrate the skill level necessa	ry to use
☐ I will notify a school staff member if I am having more difficulty than usual with my medication.	the medication prescribed by the above physician.	
	☐ Inhaler ☐ Epinephrine Auto Injector ☐ Other :	
Student Signature Date:	Nurse Signature Date:	