



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

Student 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 <input type="checkbox"/> PRN <input type="checkbox"/>	Diagnosis <input type="checkbox"/> _____ <input type="checkbox"/> _____				
Allergy	List of Allergens:	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> Other _____	<input type="checkbox"/> Dose	<input type="checkbox"/> By Mouth <input type="checkbox"/> Other _____	<input type="checkbox"/> Upon Exposure <input type="checkbox"/> Mild Reaction
		<input type="checkbox"/> Epinephrine Auto-Injector	<input type="checkbox"/> 0.15 mg <input type="checkbox"/> 0.3 mg	Intramuscular (IM) Injection	<input type="checkbox"/> Upon Exposure <input type="checkbox"/> Severe Reaction <input type="checkbox"/> If provided, repeat does after _____ minutes if symptoms continue
Asthma	Green Zone Exercise Induced	<input type="checkbox"/> Albuterol <input type="checkbox"/> Other _____	<input type="checkbox"/> 2 puffs <input type="checkbox"/> 1 ampule/vial <input type="checkbox"/> Other _____	<input type="checkbox"/> Inhaled (use spacer if provided) <input type="checkbox"/> Nebulizer	<input type="checkbox"/> DAILY before exercise <input type="checkbox"/> AS NEEDED before exercise <input type="checkbox"/> Other _____
	Yellow Zone	<input type="checkbox"/> Albuterol <input type="checkbox"/> Other _____	<input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> 1 ampule/vial <input type="checkbox"/> Other _____	<input type="checkbox"/> Inhaled (use spacer if provided) <input type="checkbox"/> Nebulizer	<input type="checkbox"/> Every 4 hours as needed <input type="checkbox"/> Other _____
	Red Zone CALL 911	<input type="checkbox"/> Albuterol <input type="checkbox"/> Other _____	CALL 911 <input type="checkbox"/> 4 puffs <input type="checkbox"/> 1 ampule/vial <input type="checkbox"/> Other _____	<input type="checkbox"/> Inhaled (use spacer if provided) <input type="checkbox"/> Nebulizer	For Emergency Symptoms
	Other Asthma Medications (EX: Symbicort, Dulera, etc.)	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> with Spacer	Please complete with specific numbers of puffs and minutes - - no ranges <input type="checkbox"/> Exercise: _____ puff(s) inhaled before exercise as needed to prevent symptoms <input type="checkbox"/> Yellow Zone: _____ puff(s) inhaled every _____ minutes for cough/wheeze/shortness of breath, up to _____ puffs Call parent/guardian if symptoms have not improved after _____ puffs. <input type="checkbox"/> Red Zone: CALL 911 - _____ puff(s) inhaled every _____ minutes up to _____ puffs		
Diabetes	<input type="checkbox"/> Glucagon <input type="checkbox"/> GVoke <input type="checkbox"/> Baqsimi <input type="checkbox"/> Other _____	<input type="checkbox"/> Dose	<input type="checkbox"/> Subcutaneous SQ <input type="checkbox"/> Intramuscular IM <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Other _____	If student becomes unconscious	
Seizure	<input type="checkbox"/> Diastat <input type="checkbox"/> Valtoco <input type="checkbox"/> Nayzilam <input type="checkbox"/> Other _____	<input type="checkbox"/> Dose	<input type="checkbox"/> Rectal Gel <input type="checkbox"/> Nasal Spray <input type="checkbox"/> Other _____	<input type="checkbox"/> Seizure Onset <input type="checkbox"/> After 5 minutes <input type="checkbox"/> After _____ minutes <input type="checkbox"/> Other _____	
Physician's Printed Name:		Physician's Tel:		Date:	MD Stamp:
Physician's Signature:		Fax:		Nurse Review/Signature/Date: _____	



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

Student Name: _____

Date of Birth: _____

School: _____

School Year: _____

To be completed by parent/guardian

I understand that:

- Non-medical personnel conduct the medication administration.
• It is my responsibility to have an adult transport the medication to school.
• If medication is not available at the school, 911 will be called for emergencies.
• If my child participates in DPS before/after-school activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition.

I request that:

- My child be administered the medication as indicated in the physician's order.
• If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

I authorize:

The release and exchange of medical information between my child's physician, school nurse and Durham Public School (DPS) system that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician.

I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

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

Student Self-Carry and Self-Administration of Medication

To be completed by Physician

The student must have the medication(s) listed on the reverse side of this form during the school day or at school sponsored events in order to function. Adult Supervision is NOT needed.

- Asthma Severe Allergy Insulin Other _____

For Epinephrine Auto Injector Only:

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 Injector and call 911.

Physician Printed Name: _____

Physician Signature: _____ Date: _____

To be completed by Student at School:

- I have demonstrated use of my medication for the school staff listed
 I plan to keep my medication and equipment with me at school.
 I will use my medication as advised by my physician.
 I will not allow any other person to use my medication.
 I will notify a school staff member if I am having more difficulty than usual with my medication.

Student Signature _____ Date: _____

To be completed by Parent/Guardian:

I request and give permission for my child to carry and give the medication listed on the reverse side during the school day, at school-sponsored activities or while in transit to or from school. Adult supervision is not needed.

I understand that:

- I shall provide the school back-up medication (in addition to what student will carry) that shall be kept at school.
• 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.
• My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

For Epinephrine Auto Injector Only:

In the event the student is experiencing respiratory difficulty and is unable to administer the 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 skill level to implement the care plan prescribed by his/her health care provider.

Parent/Guardian Signature: _____ Date: _____

To be completed by School Nurse:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

- Inhaler Epinephrine Auto Injector Other: _____

Nurse Signature _____ Date: _____