Public Health

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 ☐ 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.)	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ with Spacer	**Please complete with specific numbers of puffs and minutes - - no ranges** ☐ Exercise: ___ puff(s) inhaled before exercise as needed to prevent symptoms ☐ 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. ☐ Red Zone: **CALL 911** - ___ puff(s) inhaled every ___ minutes up to ___ puffs		
	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 Stamp:
Physician's Signature:	Fax:	Nurse Review/Signature/Date: _____	

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PARENT/GUARDIAN MUST SIGN "To be completed by parent" SECTION ON THE BACK OF THIS FORM.

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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 will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

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.** The student has been instructed in the treatment plan and self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

☐ 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:** _____