

Alamance-Burlington School System
Authorization of Medication for a Student at School

Date Received _____ Pill Count ____/____
Prescription _____ Non-Prescription _____

Please Check:

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 injection

Dosage (amount to be given): _____

How often or at what time: _____

Side effects: _____

FOR CASES WHERE SELF-MEDICATION OF EMERGENCY MEDICATION IS NECESSARY: (Prescriber's initials required.)

Student may carry and self-administer emergency 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 _____

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. I agree to allow my child's health care provider and school personnel to discuss information on this form.

Signature of Parent or Guardian

Telephone Number/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/Initials of School System Nurse/Date

Name and Title of Person to Administer Drug

Approved by: _____

Signature of Principal/Date.

Rev. 10/14 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

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)

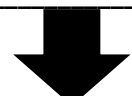
You may:

- 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.