FORM 9

INHALER AUTHORIZATION FORM

ARCHDIOCESE OF WASHINGTON – Catholic Schools

NOTE: THIS IS A RELEASE AND INDEMNIFICATION AGREEMENT AUTHORIZING USE FOR AN INHALER ONLY

PART I: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: ______________________________ Sex: ☐ Male ☐ Female Birth Date: ________
Print Student's Name *mm/dd/yyyy*

School's Name: Our Lady of Victory School School Year: 2015-2016

Allergies: ______________________________

Inhaler: ☐ Renewal ☐ NEW If new, the first full dose must be given at home to assure that the student does not have a negative reaction.

First dose was given: Date ____________ Time ____________

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here and in the Archdiocese of Washington Catholic Schools Policies and district or state guidelines.
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication Authorization forms are required for each Prescription and Over-The-Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school**.
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
   - Student name
   - Date of Birth
   - Diagnosis
   - Signs or symptoms
   - Name of medication to be given in school
   - Exact dosage to be taken in school
   - Route of medication
   - Time and frequency to give medications, as well as exact time interval for additional dosages
   - Sequence in which two or more medications are to be administered
   - Common side effects
   - Duration of medication order or effective start and end dates
   - LHCP's name, signature and telephone number
   - Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    - Name of student
    - Exact dosage to be taken in school
    - Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.

PART I: TO BE COMPLETED BY PARENT/GUARDIAN (CONTINUED)

13. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.
14. Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student. Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, EpiPen)

I hereby request designated Our Lady of Victory School **personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the Archdiocese of Washington, the parish, school personnel, employees, or agents from any lawsuit, claim, expense, demand or action, etc., against them for helping my child use an inhaler. I have read the procedures outlined above and assume responsibility as required. I am aware that the inhaler may be administered by a non-health professional.**

Name of Parent/Guardian: ______________________ Home Phone: ( ) -

Signature of Parent/Guardian: ______________________ **Date** __________

PART II: TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER WITH NO ABBREVIATIONS

Diagnosis: ______________________ List Triggers: ______________________

Signs or Symptoms: ______________________

Medication and Route: ______________________

Dosage to be given at School: ______________________ Interval for Repeating Dosage: ______________________

Time to be given: __________ Common Side Effects: ______________________

Effective Date: Start __________ End __________ If student is taking more than one medication at school, list sequence in which medications are to be taken: __________

Check ✓ appropriate boxes:

- ☐ I believe that this student has received adequate information on how and when to use an inhaler, and has demonstrated its proper use.
- ☐ The student is to carry an inhaler during school hours and during sanctioned events with principal approval (An additional inhaler, to be used as backup, WILL BE kept in the clinic or some other approved school location).
- ☐ It is not necessary for the student to carry an inhaler during school, the inhaler will be kept in the clinic or some other approved school location.
- ☐ Allergy Action Plan for the aforementioned student is attached.

Licensed Healthcare Provider: ______________________ Phone: ( ) -

Signature of LHCP: ______________________ Date __________

Parent/Guardian: ______________________ Phone: ( ) -

Signature of Parent/Guardian: ______________________ Date __________

Signature of Student (Required if student carries inhaler): ______________________

PART III: TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if Part II is written on the LHCP stationery or a prescription pad).

☐ Inhaler is appropriately labeled. ______Date by which any unused medication is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

☐ I have reviewed the proper use of the inhaler with the student and ☐ agree / ☐ disagree that the student should self carry in school.

Signature of Principal/Nurse: ______________________ Date __________

Asthma Action Plan

Name	School	DOB / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	
Additional Emergency Contact	Contact Phone	

DO NOT WRITE IN THIS SPACE

Place Patient Label Here

Asthma Severity *(see reverse side)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals________
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:________________

Date of Last Flu Shot: ___ /___ /___

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 in this area:
_________ to_________
(More than 80% of Personal Best)

Personal best peak flow:___________

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ ______________________________ , ______ puff(s) inhaler **with spacer**_____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

☐ ______________________________ , _____ nebulizer treatment(s)_____ times a day
Inhaled corticosteroid

☐ ______________________________ , take_____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ ______________ , _______ puff(s) inhaler with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist

For nasal/environmental allergy, ADD:
☐ ______________________________

Yellow Zone: Caution!–Continue CONTROL Medicines and ADD QUICK-RELIEF Medicines

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

Peak flow in this area:
_________ to_________
(50%-80% of Personal Best)

☐ ______________ , ______ puff(s) inhaler **with spacer** every ______ hours as needed
Fast-acting inhaled β–agonist

OR

☐ ______________ , ______ nebulizer treatment(s) every ______ hours as needed
Fast-acting inhaled β–agonist

☐ Other______________________________

Call your DOCTOR if you have these signs more than two times a week, *or* if your quick-relief medicine doesn't work!

Red Zone: EMERGENCY!–Continue CONTROL & QUICK-RELIEF 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 in this area:
Less than _________
(Less than 50% of Personal Best)

☐ ______________ , ____ puff(s) inhaler with spacer **every 15 minutes,** for **3** treatments
Fast-acting inhaled β–agonist

OR

☐ ______________ , ____ nebulizer treatment **every 15 minutes,** for **3** treatments
Fast-acting inhaled β–agonist

Call your doctor while giving the treatments.

☐ Other______________________________

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

REQUIRED Healthcare Provider Signature:

________________________ Date: __________

REQUIRED Responsible Person Signature:

________________________ Date: __________

Follow up with primary doctor in 1 week or:

____________________ Phone:______________

☐ Patient/parent has doctor/clinic number at home

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of quick-relief medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.
Healthcare Provider Initials:
_____This student is capable and approved to self-administer the medicine(s) named above.
_____This student is not approved to self-medicate.
This authorization is valid for one calendar year.
As the RESPONSIBLE PERSON:
☐ I hereby authorize a trained school employee, if available, to administer medication to the student.
☐ I hereby authorize the student to possess and self-administer medication.
☐ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

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