Asthma Medication Administration Record (MAR) Part 1

(Parent/Guardian signature required on Part 2) A completed form must be provided before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student Photo (Must attach)

A			
Student name	❑ Male ❑ Female Date of birth	Student address	Student ID# _____
Grade/Class	Teacher	School	

Medication order in this section must be signed by the prescriber

Medication Name & Start /End Date	Dosage Route & Time Interval	Possible Severe Adverse Reactions	Special Instructions (Choose all that are appropriate)
1. Medication: 1 Albuterol HFA_____ Brand (circle): Pro Air, Ventolin, Proventil Levalbuterol HFA _____ Brand (circle): Xopenex **1. Asthma Diagnosis** ❑ Yes ❑ No If No, list Diagnosis:_____ Asthma Severity: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise Begin Date: _____ End Date (if known):_____	❑ **Standard Order:** ❑ 2 puffs ❑ 4 puffs ❑ 6 puffs 2 PRN (as needed) via MDI every ❑ 4 hours ❑ 4-6 hours PRN (as needed) for cough, wheeze, tightness in chest, difficulty breathing or shortness of breath May repeat in:_____ minutes x _____ if no improvement for a total of _____ times. ❑ **Pre-exercise:** 2 puffs via MDI 5 to 20 minutes before exercise Ordered inhalers with spacer _____ (spacer name)	**Possible Serve Adverse Reactions per Orc 3313.716** 3 ❑ To the student for whom it is prescribed (that should be reported to the physician) _____ _____ ❑ To the student for whom it is **NOT** prescribed who receives a dose _____ _____ ❑ Other _____ _____	**Special Instructions** 4 ❑ Student may carry medication and may self-administer (Parent must complete Part 2) ❑ Provide training on proper inhaler use ❑ See Action Plan ❑ Procedures to follow if the medication does not produce the expected relief: _____ _____ ❑ Store medication in school health room and student to self administer under observation. ❑ Store medication in school health room and designated school employee to administer ❑ Other:_____ _____
2. Medication: Diagnosis:_____ Begin Date: _____ End Date (if known):_____	❑ **Standing Daily Dose** Specify Time:_____am and/or ❑ pm_____ Time Interval: every (q) _____ hours as needed _____ _____ (specify signs, symptoms or situations)	**Possible Serve Adverse Reactions Reportable to Prescriber:** _____ _____ _____	**Special Instructions** ❑ Store medication in school health room and designated school employee to administer ❑ Requires refrigeration ❑ Other:_____ _____
3. Medication: Diagnosis:_____ Begin Date: _____ End Date (if known):_____	❑ **Standing Daily Dose** Specify Time:_____am and/or ❑ pm_____ Time Interval: every (q) _____ hours as needed _____ _____ (specify signs, symptoms or situations)	**Possible Serve Adverse Reactions Reportable to Prescriber:** _____ _____ _____	**Special Instructions** ❑ Store medication in school health room and designated school employee to administer ❑ Requires refrigeration ❑ Other:_____ _____
List home medication(s) 5 _____ _____ _____ _____	**Prescriber** (please print): 6 _____ **Prescriber Address:** _____ _____	**Prescriber Signature/Date:** 6 _____ **Prescriber Emergency Phone:** _____ Fax: _____	For Nurse Use Only: (Revision per Licensed Nurse after consultation with prescribing provider) _____ _____

HEA 7774 5/11 Copies provided to_____Teachers_____PE/Coach _____ Bus other _____

Cornerstone Christian Academy
Asthma Medication Administration Record

Prescriber order(s) and signature required on Part 1. A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

A

Student Information

Student name	Date of birth
Student address	Grade/Classroom

B

Parent Authorization

- ☑ I authorize a designated employee of the school board to administer the prescriber's medication as ordered for my child.
- ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
- ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication.
- ☑ Medication and medication form must be received by the principal, his/her designee, or the school nurse.
- ☑ I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.
- ☑ I agree that it is important to keep a backup rescue asthma inhaler at the school's designated location.
- ☑ I understand I must come into the school office/clinic when my child's medication is discontinued by the prescriber at the end of the school year, or medication will be disposed of one week post discontinuation orders or school year end.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone
		( )	( )

C

Parent/Guardian Self-Carry Authorization

(Parent must ☑ below to indicate student is allowed to self-carry their inhaler)

- ❑ I authorize and recommend self-medication by my child for the prescribed listed medication.
- ❑ I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending prescriber.

Parent/Guardian signature	Date	Phone	Cell
		( )	( )

D

Do not write below (For school staff only)

Reviewed by	Title/Position	Date
Comments		

❑ File per district policy