# Runnels School Physician's Orders

(A licensed physician or dentist must complete this request for medication administration at school)

Student: _____ DOB: _____ Gender:_____Grade: _____

Student Diagnosis (all): _____Allergies: _____

Student general health status: _____

**Medication to be given at school**:

| Medication | Dosage | Route | Time |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Date to begin:_____(**expires in 12 months unless specified in next blank**) Date to end:_____

Next office visit:_____

List contraindications or child-specific potential side effects to watch for at school: _____

_____

**Use this section only for students who will administer their own medication, such as an inhaler or Epipen.**

Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of this medication to the degree that he/she may self-administer his/her medication at school provided the school nurse has determined it is safe and appropriate for this particular student in this particular setting? ◯ **Yes** ◯ **No**

Comments: _____

**Physician Signature**: _____Date: _____

Physician's Name (print/stamp): _____Office phone: _____

Office Address: _____Office Fax: _____

## Parent/Guardian Consent For Medication Administration at School

Special instructions for administration of above medication: _____

Has initial administration of above medication been given at home and has sufficient time passed (24 hours) to observe for adverse reactions before asking school personnel to administer medication. ◯ **Yes** ◯ **No**

Do you give permission for the school nurse, and in her absence unlicensed school personnel, to administer this medication? ◯ **Yes** ◯ **No**

**Use this box for the student who will administer his/her own medications, such as an asthma inhaler or Epipen.**

***The student is required to notify the nurse in an event of self-administration. School Policy states that no child can carry medication on their person, book bag or lunchbox, etc., except for inhalers and other life-saving pharmaceuticals approved by the school nurse.***

Do you give permission for your child to self-administer medication if the school nurse determines that is safe and appropriate? ◯ **Yes** ◯ **No**
Do you believe your child is sufficiently responsible and informed to administer his/her own medications? ◯ **Yes** ◯ **No**
Do you assume responsibility for your child's actions in his/her self-management of medication at school? ◯ **Yes** ◯ **No**
Do you understand that regular medication orders must be provided for students who self-administer medications at school? ◯ **Yes** ◯ **No**

I understand and agree that Runnels School and its employees are not responsible for any unintentional mistakes in keeping or giving my child's medication. I agree to hold Runnels School free and harmless of liability from injuries that might occur as a result of the administration of medications by school employees.

**Parent/Guardian Signature**: _____Date: _____

**Parent/Guardian Print Name**: _____

Revised 6/15

# Runnels School Airway Action Plan

Student _____ DOB _____ Gender: ◯M /◯F Grade _____

Contact Numbers: (mom) HOME _____ WORK _____ CELL _____

(dad) HOME _____ WORK _____ CELL _____

Emergency Contact Name _____ PHONE _____

## To Be Completed By Health Care Provider

Airway Diagnosis: ◯ Asthma ◯ EIB ◯ VCD ◯ RAD ◯ Other _____

Please circle student's known trigger(s): ◯ Pollens ◯ Stress/anxiety ◯ Cold air ◯ Exercise

Allergy (please specify) _____ other trigger(s) _____

Current medications **taken at home** for Airway Control

1. _____ 2. _____ 3. _____

Medications to be given at school for Airway Control **(Requires completed Physician Order Form)**

1. _____ 2. _____ 3. _____

Is student capable and responsible for self-administration of this medication? ◯ Yes ◯ No

May student carry inhaler (10 yrs. and older)? ◯ Yes ◯ No

Personal Peak Flow _____

If Airway Restriction occurs at school follow these steps:

1. _____

2. _____

3. _____

Other special instructions: _____

Health Care Provider Signature _____ Date_____

## To Be Completed By Parent/Guardian

**I understand that:**

- ✳ to give medications at school, the Physicians Order form is also required specifying medication and the dosage with routine time.
- ✳ if symptoms are not relieved by steps taken above, school personnel will activate the 911 emergency system
- ✳ if my child does not keep an inhaler in the health office and/or self-administers medication in locations other than the clinic, it is my responsibility to review with my child when he/she should come to the health office for additional medical assistance.

Additional Comments: _____

Parent/Guardian Signature _____ Date_____

Revised 1/17