Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2025-2026

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include: ATS DBN/Name, address, and borough): _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other: _____

Control (*see NAEPP Guidelines*)
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity (*see NAEPP Guidelines*)
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent
- ☐ Unknown

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐ Y	☐ N	☐ U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐ Y	☐ N	☐ U	
History of asthma-related PICU admissions (ever)	☐ Y	☐ N	☐ U	
Received oral steroids within past 12 months	☐ Y	☐ N	☐ U	____ times last: _____
History of asthma-related ER visits within past 12 months	☐ Y	☐ N	☐ U	____ times last: _____
History of asthma-related hospitalizations within past 12 months	☐ Y	☐ N	☐ U	____ times last: _____
History of food allergy or eczema, specify: _____	☐ Y	☐ N	☐ U	
Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)?	☐ Y	☐ N	☐ U	

Home Medications (include over the counter) ☐ **None**

☐ Reliever: _____ ☐ Controller: _____ ☐ Other: _____

Student Skill Level (select the most appropriate option):
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/self-administer
  - ☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school-sponsored events. Practitioner's Initials: _____

Quick Relief In-School Medication

(individual spacers are provided by the school)

Emergency Plan: If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!

Standard Order: *Albuterol 2 puffs followed by 1 puff fluticasone will be used if prescribed medication below is not available*
Give 2 puffs albuterol followed by 1 puff fluticasone every 4hrs PRN for cough, wheezing, difficulty breathing, chest tightness or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.

☐ **Pre-exercise**: Name: _____ Dose: _____ puffs/ _____ AMP 15-20 mins before exercise.

☐ **URI Symptoms/Recent Asthma Flare:** 2 puffs at noon for 5 school days when directed by PCP
Name: _____ Dose: _____ puffs/ _____ AMP q ____ hrs.

Other Quick Relief Medication: SMART/MART (ginasthma.org)

☐ Symbicort: Strength: _____ Dose: ☐ 1 puff ☐ 2 puffs every 4 hours PRN. *If not symptom-free within 20 mins may repeat ONCE*

☐ Airsupra: (albuterol & budesonide) Strength_____Dose____puffs every ___hrs PRN. *If not symptom-free within 20 mins may repeat ONCE*

☐ Albuterol with ICS: ☐ Albuterol ___puffs followed by Fluticasone _____ puffs every _____hrs PRN. *If not symptom-free in 20 mins may repeat ONCE*

☐ Albuterol ___puffs followed by Qvar_____ puffs every ___hrs PRN. *If not symptom-free in 20 mins may repeat ONCE*

Special Instructions: _____

Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

Fluticasone 110 mcg will be used if prescribed medication below is not available

☐ Fluticasone *[Only Fluticasone® 110 mcg MDI is provided by school for shared usage]* ☐ Stock ☐ Parent Provided
Standing Daily Dose: ____ puff (s) ☐ one OR ☐ two time(s) a day Time: _____ AM and _____PM

☐ Symbicort **(provided by parent)**. Standing Daily Dose: ____ puff (s) ☐ one OR ☐ two time(s) a day Time: _____ AM and _____PM
Special Instructions: _____

☐ Other ICS (provided by parent) Standing Daily Dose:
Name: _____Strength: _____ Dose: ____Route: _____Frequency: ☐ one OR ☐ two time(s) a day Time: _____AM &_____PM

Health Care Practitioner

Last Name (Print): _____ First Name (Print): _____ ☐ MD ☐ DO ☐ NP ☐ PA

Signature: _____ Date: _____ NYS License # (Required): _____ NPI #: _____

Completed by Emergency Department Medical Practitioner: ☐ Yes ☐ No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)

Address: _____ E-mail address: _____

Tel: _____ FAX: _____ Cell Phone: _____

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

FORMS CANNOT BE COMPLETED BY A RESIDENT
INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS.

PARENTS MUST SIGN PAGE 2 →

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Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse/School Based Health Center (SBHC) my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the Office of School Health (OSH) giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the doctor's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize OSH to provide health services to my child.These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse/ SBHC stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through the OSH medical team. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

   NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved medications with your child for a school trip day and/or an after school program. Stock medications are only for use in school by OSH staff.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse/SBHC will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: ____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Parent/Guardian Cell Phone: _____ Other Phone: _____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone: _____

For Office of School Health (OSH) Use Only

OSIS Number: _____ **Received by** - Name: _____ Date: _____

☐ 504 ☐ IEP ☐ Other _____ **Reviewed by** - Name: _____ Date: _____

Referred to School 504 Coordinator: ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only)

☐ School Based Health Center ☐ OSH Asthma Case Manager *(For supervised students only)*

Signature and Title (RN OR MD/DO/NP): _____

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified