



## Durham Public Schools Parent Request and Providers' Order Form for Medication

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_ School Year: \_\_\_\_\_

|                                                                | Diagnosis                                                                     | Medication Name<br><b>Right</b> Medication                                                                                                                                   | Dosage<br><b>Right</b> Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | How to Give<br><b>Right</b> Route                                                                                                                                     | When to Give<br><b>Right</b> Time                                                                                                                                                       |
|----------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DAILY <input type="checkbox"/><br>PRN <input type="checkbox"/> | Diagnosis<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ |                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                       |                                                                                                                                                                                         |
| <b>Allergy</b>                                                 | List of Allergens:                                                            | <input type="checkbox"/> Diphenhydramine (Benadryl)<br><input type="checkbox"/> Other _____                                                                                  | <input type="checkbox"/> Dose _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> By Mouth<br><input type="checkbox"/> Other _____                                                                                             | <input type="checkbox"/> Upon Exposure<br><input type="checkbox"/> Mild Reaction                                                                                                        |
|                                                                |                                                                               | <input type="checkbox"/> Epinephrine Auto-Injector                                                                                                                           | <input type="checkbox"/> 0.15 mg<br><input type="checkbox"/> 0.3 mg                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Intramuscular (IM) Injection                                                                                                                                          | <input type="checkbox"/> Upon Exposure<br><input type="checkbox"/> Severe Reaction<br><input type="checkbox"/> If provided, <b>repeat does after _____ minutes if symptoms continue</b> |
| <b>Asthma</b>                                                  | Green Zone<br>Exercise Induced                                                | <input type="checkbox"/> Albuterol<br><input type="checkbox"/> Other _____                                                                                                   | <input type="checkbox"/> 2 puffs<br><input type="checkbox"/> 1 ampule/vial<br><input type="checkbox"/> Other _____                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Inhaled (use spacer if provided)<br><input type="checkbox"/> Nebulizer                                                                       | <input type="checkbox"/> DAILY before exercise<br><input type="checkbox"/> AS NEEDED before exercise<br><input type="checkbox"/> Other _____                                            |
|                                                                | Yellow Zone                                                                   | <input type="checkbox"/> Albuterol<br><input type="checkbox"/> Other _____                                                                                                   | <input type="checkbox"/> 2 puffs<br><input type="checkbox"/> 4 puffs<br><input type="checkbox"/> 1 ampule/vial<br><input type="checkbox"/> Other _____                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Inhaled (use spacer if provided)<br><input type="checkbox"/> Nebulizer                                                                       | <input type="checkbox"/> Every 4 hours as needed<br><input type="checkbox"/> Other _____                                                                                                |
|                                                                | Red Zone<br><b>CALL 911</b>                                                   | <input type="checkbox"/> Albuterol<br><input type="checkbox"/> Other _____                                                                                                   | <b>CALL 911</b><br><input type="checkbox"/> 4 puffs<br><input type="checkbox"/> 1 ampule/vial<br><input type="checkbox"/> Other _____                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Inhaled (use spacer if provided)<br><input type="checkbox"/> Nebulizer                                                                       | For Emergency Symptoms                                                                                                                                                                  |
|                                                                | Other Asthma Medications<br>(EX: Symbicort, Dulera, etc.)                     | <input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> with Spacer | <b>Please complete with specific numbers of puffs and minutes - - no ranges</b><br><input type="checkbox"/> Exercise: _____ puff(s) inhaled before exercise as needed to prevent symptoms<br><input type="checkbox"/> Yellow Zone: _____ puff(s) inhaled every _____ minutes for cough/wheeze/shortness of breath, up to _____ puffs.<br>Call parent/guardian if symptoms have not improved after _____ puffs.<br><input type="checkbox"/> Red Zone: <b>CALL 911</b> - _____ puff(s) inhaled every _____ minutes up to _____ puffs |                                                                                                                                                                       |                                                                                                                                                                                         |
|                                                                | <b>Diabetes</b>                                                               | <input type="checkbox"/> Glucagon<br><input type="checkbox"/> GVOKE<br><input type="checkbox"/> Baqsimi<br><input type="checkbox"/> Other _____                              | <input type="checkbox"/> Dose _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Subcutaneous SQ<br><input type="checkbox"/> Intramuscular IM<br><input type="checkbox"/> Nasal Spray<br><input type="checkbox"/> Other _____ | If student becomes unconscious                                                                                                                                                          |
|                                                                | <b>Seizure</b>                                                                | <input type="checkbox"/> Diastat<br><input type="checkbox"/> Valtoco<br><input type="checkbox"/> Nayzilam<br><input type="checkbox"/> Other _____                            | <input type="checkbox"/> Dose _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Rectal Gel<br><input type="checkbox"/> Nasal Spray<br><input type="checkbox"/> Other _____                                                   | <input type="checkbox"/> Seizure Onset<br><input type="checkbox"/> After 5 minutes<br><input type="checkbox"/> After _____ minutes<br><input type="checkbox"/> Other _____              |
| Physician's Printed Name:                                      |                                                                               | Physician's Tel:                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Date:                                                                                                                                                                 | MD Stamp:                                                                                                                                                                               |
| Physician's Signature:                                         |                                                                               | Fax:                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Nurse Review/Signature/Date: _____                                                                                                                                    |                                                                                                                                                                                         |



## Durham Public Schools Parent Request and Providers' Order Form for Medication

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

School Year: \_\_\_\_\_

## To be completed by parent/guardian

## I understand that:

- Non-medical personnel conduct the medication administration.
- It is my responsibility to have an adult transport the medication to school.
- If medication is not available at the school, 911 will be called for emergencies.
- If my child participates in DPS before/after-school activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

## I request that:

- My child be administered the medication as indicated in the physician's order.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

## I authorize:

The release and exchange of medical information between my child's physician, school nurse and Durham Public School (DPS) system that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician.

I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Print Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ DATE: \_\_\_\_\_ Phone: \_\_\_\_\_

## Student Self-Carry and Self-Administration of Medication

## To be completed by Physician

The student must have the medication(s) listed on the reverse side of this form during the school day or at school sponsored events in order to function. **Adult Supervision is NOT needed.** The student has been instructed in the treatment plan and self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

☐ Asthma ☐ Severe Allergy ☐ Insulin ☐ Other \_\_\_\_\_

## For Epinephrine Auto Injector Only:

In the event the student is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector, the school nurse will train designated school staff to administer the Epinephrine Auto Injector and call 911.

Physician Printed Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## To be completed by Student at School:

- ☐ I have demonstrated use of my medication for the school staff listed
- ☐ I plan to keep my medication and equipment with me at school.
- ☐ I will use my medication as advised by my physician.
- ☐ I will not allow any other person to use my medication.
- ☐ I will notify a school staff member if I am having more difficulty than usual with my medication.

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

## To be completed by Parent/Guardian:

I request and give permission for my child to carry and give the medication listed on the reverse side during the school day, at school-sponsored activities or while in transit to or from school. Adult supervision is not needed.

I understand that:

- I shall provide the school back-up medication (in addition to what student will carry) that shall be kept at school.
- My child will be required to demonstrate the skill level necessary to use the self-administered emergency medication to school staff trained by the school nurse.
- My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

## For Epinephrine Auto Injector Only:

In the event the student is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the Epinephrine Auto Injector and call 911. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## To be completed by School Nurse:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

☐ Inhaler ☐ Epinephrine Auto Injector ☐ Other : \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date: \_\_\_\_\_