



ST. MICHAEL'S SCHOOL

100 ALDEN STREET • CRANFORD, NEW JERSEY 07016 • (908) 276-9425

MEDICATION ADMINISTRATION POLICY

Dear Parents/Guardians,

If it is necessary for your child to take medication during school hours, the following guidelines must apply:

- A Medication Authorization Form must be completed and signed by the Physician. This form is submitted annually for children who need meds given during school hours. (The forms are in the nurses office)
- The Physician must specify the medication, dosage, frequency, route of administration and indication.
- The Parent/Guardian must give permission for the school nurse or in her absence, the principal or her designee, to administer the medication.
- The medication must be brought to the health office in its original container with the pharmacy label intact. The label must indicate the child's name, the medication, dosage and frequency of administration.
- A child MAY NOT keep medication with him/her in the classroom.
- PLEASE NOTE: The above applies to over-the-counter medication as well as prescription medication.

All required forms are available in the health office. If you have any questions or concerns, don't hesitate to call.

Maria Polo
Maria Polo, RN



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MEDICATION AUTHORIZATION DURING SCHOOL HOURS

To be completed by PARENT:

Child's Name _____ School _____

Physician's Name _____ Address _____ Phone _____

I request that authorized personnel assist my child in taking the medicine described below during school hours.

Date _____ Parent/Guardian Signature _____ Emergency Phone # _____

To be completed by PHYSICIAN:

Diagnosis: _____

Medication: _____

Dosage: _____

Route _____ Time: _____

If medicine is to be given "when needed", describe indications: _____

How soon can it be repeated? _____

Length of time this treatment is recommended? _____

If INHALER, is child allowed to have one on his/her person? _____

This child is capable of and has been instructed in the proper administration of this medication _____

Date _____ Physician's Signature _____

Asthma Action Plan

Date Completed _____

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

Intermittent Persistent Mild Moderate Severe

ASTHMA TRIGGERS (Things That Make Asthma Worse)

Smoke Colds Exercise Animals Dust Food
 Weather Odors Pollen Other _____

GREEN ZONE: GOOD Take these DAILY CONTROLLER MEDICINES (PREVENTION) Medicines EVERY DAY

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night



- No daily controller medicines required
- Daily controller medicine(s): _____

 Take _____ puff(s) or _____ tablet(s) _____ daily.
- For asthma with exercise, ADD: _____
 _____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing



Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines

- Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:
- _____ inhaler _____ mcg
 Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask.
- _____ nebulizer _____ mg / _____ ml
 Take a _____ nebulizer treatment every _____ hours, if needed.
- Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider
 If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider
IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY! Continue DAILY CONTROLLER MEDICINES and QUICK-RELIEF Medicines and GET HELP!

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish



- _____ inhaler _____ mcg
 Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask.
- _____ nebulizer _____ mg / _____ ml
 Take a _____ nebulizer treatment every _____ hours, if needed.
- Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ - _____.

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____