



Davison Community Schools
1490 N. Oak Rd. Davison, MI 48423
Phone (810) 591-0913 Fax (810) 591-2674
Authorization to Administer Medication

Student Name _____ School _____

Teacher _____ Room Number _____ Grade _____

Physician's Order (Must be completed by physician or designee)

Name of medication _____		Reason for medication _____	
Dose _____		Time to be Given _____	
For episodic/emergency use only <input type="checkbox"/> yes <input type="checkbox"/> no			
Route to be given (please check)			
<input type="checkbox"/> by mouth (<input type="checkbox"/> capsule <input type="checkbox"/> tablet <input type="checkbox"/> liquid)			
<input type="checkbox"/> injection			
<input type="checkbox"/> inhaler/nebulizer			
<input type="checkbox"/> drops			
<input type="checkbox"/> other _____			
Side effects to observe: <input type="checkbox"/> none anticipated <input type="checkbox"/> yes, describe _____			
Special storage considerations: <input type="checkbox"/> none <input type="checkbox"/> refrigerate			
Start date _____		Stop date _____	
End of school year _____			
<u>Self-Administration</u>			
This student is both capable and responsible for carrying and self-administering this medication. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician Name _____		Phone Number _____	
Address _____			
Physician Signature _____		Date _____	

Parent/Guardian Authorization to Administer Medication (Must be completed by parent or guardian)

I have read the school's policy and procedures pertaining to administration of medication. I agree to follow the procedures and request that (student's name) _____

_____ Receive the medication specified above at school according to school policy and procedure.

_____ Request that my child be allowed to self-administer the medication specified above according to school policy and procedure. *(Can only be requested with physician's written approval above.)*
(Note: School policy does not allow students to self administer controlled substances.)

Parent/Guardian Signature _____ Date _____

Home phone _____ Cell phone _____ Work phone _____

Office Use Only






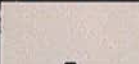
Date received _____	Number of pills received _____	Date medication returned to parent _____
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Please Fill Out Both Sides!

Asthma Action Plan

Name	Date of Birth	Effective Date / / to / /
Doctor	Parent/Guardian	
Doctor's Office Phone Number: Day	Parent's Phone	
Emergency Contact After Parent	Contact Phone	
Student is able to self medicate <input type="checkbox"/> Yes <input type="checkbox"/> No		

The colors of a traffic light will help you use your asthma medicines. Also pay attention to symptoms

	Green means GO ZONE Use preventive medicine	
	Yellow means CAUTION ZONE! Add prescribed yellow zone medicine	
	Red means DANGER ZONE! Get help from a doctor	

GO (GREEN)

Use these medicines every day.

You have **ALL** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work or play



Peak flow above _____

Medicine	How Much to Take	When to Take It
For asthma with exercise, take:		

CAUTION (YELLOW)

Continue with green zone medicine and **ADD**:

You have **ANY** of these:

- First sign of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night



And/or Peak flow from _____ to _____

Medicine	How Much to Take	When to Take It
First →		
Next →		

➔ IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK, THEN CALL YOUR DOCTOR.

DANGER (RED)

Take these medicines and call your doctor.

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips and/or fingernails blue
- Trouble walking and talking



And/or Peak flow below _____

Medicine	How Much to Take	When to Take It

Get help from a doctor now! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It is IMPORTANT! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Check all items that trigger your asthma and things that could make your asthma worse:

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Ozone alert days | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Cigarette Smoke and second hand smoke | <input type="checkbox"/> Pests-rodents and cockroaches | _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Pets-animal dander | _____ |
| <input type="checkbox"/> Dust mites, dust, stuffed animals, carpet | <input type="checkbox"/> Plants, flowers, cut grass, pollen | <input type="checkbox"/> Other |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors, perfumes, | _____ |
| <input type="checkbox"/> Sudden temperature change | <input type="checkbox"/> cleaning products | _____ |
| <input type="checkbox"/> Mold | <input type="checkbox"/> Wood Smoke | _____ |

Asthma Triggers



Adapted from the original design by the Pediatric Asthma Coalition of New Jersey

Doctor's Signature/Stamp