Trinity Lutheran School

Request for Self-Administration of Asthma Medication
Request for Self-Administration of Allergy Medication (Epinephrine Auto-Injector)

Part 1: To be completed by a Physician licensed to practice medicine in all branches, Physician Assistant, or Advanced Practice Registered Nurse

Student Name: ______________________________ Birthdate: ______________________________

Name of Medication: ______________________________

Dosage: ______________________________

Route of Administration: ______________________________

Frequency and Time of Administration: ______________________________

Diagnosis: ______________________________

Other medications student is receiving: ______________________________

Possible Side Effects: ______________________________

Start Date: ______________________________ Stop Date: ______________________________

I, ______________________________, have in-serviced the above named student regarding the prescribed inhaler or the epinephrine auto-injector and its proper use. I am requesting that he/she be allowed to carry the inhaler or the epinephrine auto-injector on his/her person and assume full responsibility for its use during school hours and extracurricular activities.

Licensed Prescriber: (print) ______________________________ Signature: ______________________________

Address: ______________________________

____

*Health Care Provider: Please complete the Asthma Action Plan on the reverse side of this sheet.

Telephone: ______________________________

Date: ______________________________

Part 2: To be completed by the parent or legal guardian

I, ______________________________, request and give permission for my son/daughter to carry the prescribed inhaler or epinephrine auto-injector on his/her person. I accept full responsibility for my child's ability to properly use the inhaler or epinephrine auto-injector. I hereby release Trinity Lutheran School and its employees from any responsibility to the use/misuse of the inhaler or epinephrine auto-injector by my son/daughter. I will obtain a new doctor's order if there is a change in the prescribed inhaler or epinephrine auto-injector. Lastly, I hereby give permission for the school's Administration to discuss the details of this order with the Licensed Prescriber.

Parent/Legal Guardian: ______________________________ Date: ______________________________

Address: ______________________________ Telephone: ______________________________

____

ASTHMA HEALTH CARE PLAN

Name: ______________________________ Date: ______________________________

Regular HCP ☐ 504 HCP ☐

Birthdate: ______________________________

School: ______________________________

Grade: ______________________________

What Triggers Asthma Problems: ______________________________

GREEN – MAINTENANCE

Breathing is good
No coughing or wheezing
Can work and play
Peak Flow Number if Available
_________ to _________

Medication & Dose: ______________________________

When to give: ______________________________

YELLOW – CAUTION

Coughing
Wheezing
Tight Chest
Peak Flow Number if Available
_________ to _________

Medication & Dose: ______________________________

When to give: ______________________________

RED – DANGER

Medicine is not helping
Breathing is hard and fast
Nose opens wide
Can't talk well or walk
Peak Flow Number if Available
_________ to _________

Medication & Dose: ______________________________

When to give: ______________________________

DON'T HESITATE TO CALL 911

Health action plan: ______________________________

Other health concerns: ______________________________

Inhaler use demonstrated to ______________________________ Yes_______ No________

Dietary concerns/restrictions: ______________________________

M.D. Signature*: ______________________________ Date: ______________________________

*signature required

Primary Care Physician: ______________________________ Phone: ______________________________

Specialty M.D. ______________________________ Phone: ______________________________