NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

MEDICATION ORDER

For online forms: ***http://sbo.nn.k12.va.us/healthservices/medications.html***

It is best if students can take medication at home. When this is not possible, Newport News Public Schools will cooperate in the administration of medication during school hours. **These procedures must be followed for all prescription medications, all over the counter drugs & supplements and herbal remedies.**

1. Written orders, from a medical provider, detailing the name of the drug, dosage and time interval medication is to be taken must be on file. Medication ordered 3 times a day or less cannot be given without a specific time. Orders should specify a time since lunch time can be anywhere from 10:30 am to 1:00 pm.

2. The signature of parent or guardian requesting that the school division comply with the physician's order is required. Medication will be given by the school nurse or school personnel designated by the principal.

3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy or medical provider. Bring only that amount of medication to be taken during school hours. Extra medication must be picked up by a parent. Advil, Tylenol, and other over the counter medicines must be handled the same as prescription drugs and be in an original container. Expired drugs will not be given.

Please complete and sign this form (*Medical Providers are asked to complete the Asthma Action Plan on the reverse side of this form for students with Asthma*):

Name of Child: ____

Diagnosis: ____

Date of Order: ____

Name of Medication: ____

Dosage: _____________________________________Time: _________________________

Duration of Order: ____

(Duration cannot exceed current school year.)

Comments: ____

_____ Student needs to carry this medication on his/her person at all times, has been trained by medical provider on how to use, and understands when to seek assistance.

Medical Provider's Signature: ____

Print: ______________________________________ Phone Number: ___________________

I request that the school give the above medications as ordered by the provider. I give permission for the school nurse to contact the medical provider if indicated to carry out this order.

____________________________________ ________________________________

School Student Attends | Parent or Guardian

R-7/20

Virginia Asthma Action Plan

School Division:

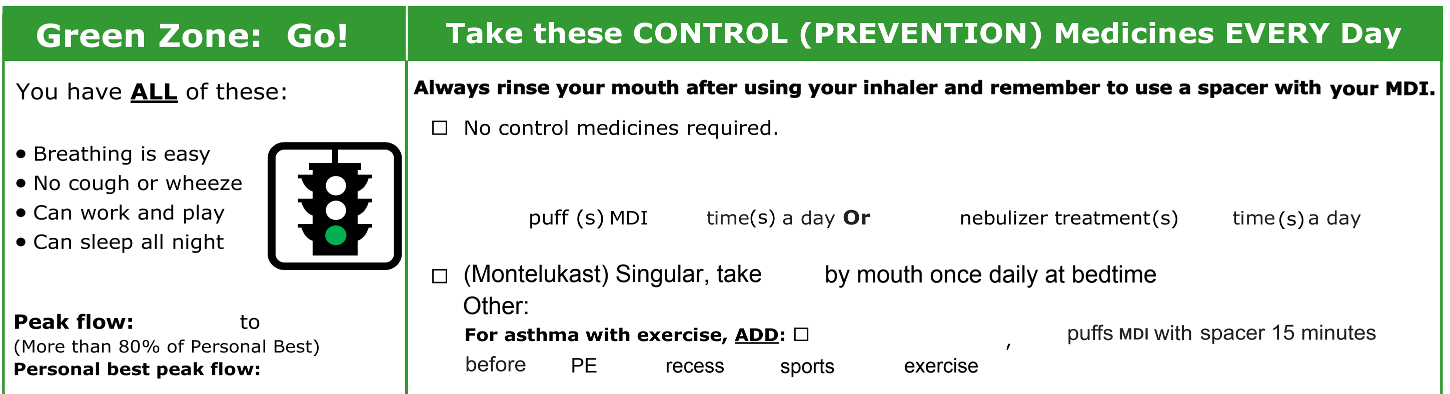
Name			**Date of Birth**
Health Care Provider	**Provider's Phone #**	**Fax #**	**Last flu shot**
Parent/Guardian	**Parent/Guardian Phone**		**Parent/Guardian Email:**
Additional Emergency Contact	**Contact Phone**		**Contact Email**

Asthma Triggers **(Things that make your asthma worse)**

				Season
☐ Colds	☐ Dust	☐ Animals:________________	☐ Strong odors	☐ Fall ☐ Spring
☐ Smoke (tobacco, incense)	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/moisture	☐ Winter ☐ Summer
☐ Pollen	☐ Exercise	☐ Other:________________	☐ Stress/Emotions	

▼ **Medical provider complete from here down** ▼

Asthma Severity:



Green Zone: Go!

You have **ALL** of these:

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

Peak flow: to
(More than 80% of Personal Best)
Personal best peak flow:

Take these CONTROL (PREVENTION) Medicines EVERY Day

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

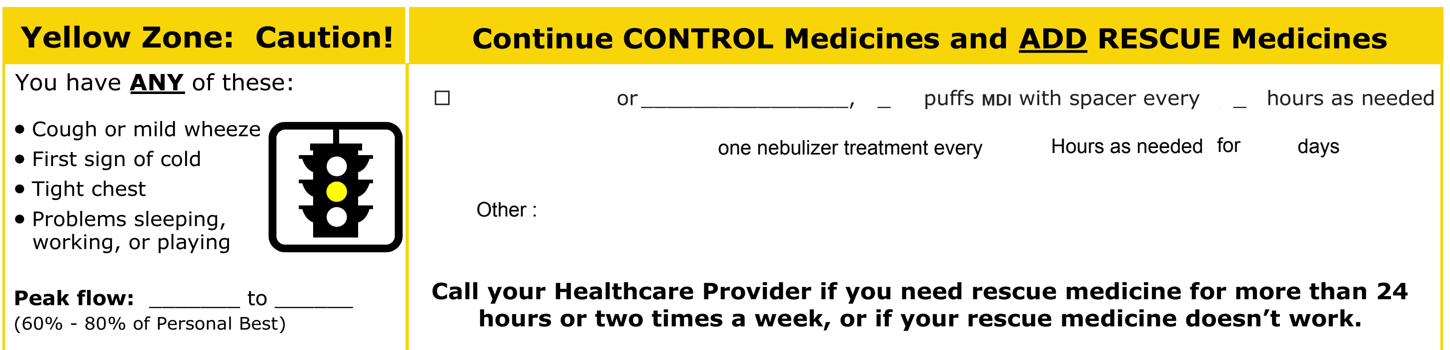
☐ No control medicines required.

puff (s) MDI time(s) a day **Or** nebulizer treatment(s) time(s) a day

☐ (Montelukast) Singular, take by mouth once daily at bedtime

Other:

For asthma with exercise, ADD: ☐ , puffs MDI with spacer 15 minutes before PE recess sports exercise



Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow: ________ to _______
(60% - 80% of Personal Best)

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ or _________________, _ puffs MDI with spacer every _ hours as needed

one nebulizer treatment every Hours as needed for days

Other :

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow: < ________
(Less than 60% of Personal Best)

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ , puffs MDI with spacer **every 15 minutes**, for **THREE** treatments

☐ , one nebulizer treatment **every 15 minutes**, for **THREE** treatments

Other :

Call your doctor while administering the treatments.
IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN ______________________ Date ________

SCHOOL NURSE/DESIGNEE ______________________ Date ________

OTHER ______________________ Date ________

CC: ☐ Principal ☐ Cafeteria Mgr ☐ Bus Driver/Transportation ☐ School Staff ☐ Coach/PE ☐ Office Staff ☐ Parent/guardian

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

Check One:

☐ Student, in my opinion, can carry and self-administer inhaler at school.

☐ Student needs supervision or assistance to use inhaler, and should not carry the inhaler in school.

MD/NP/PA SIGNATURE: ______________________ DATE ________

Effective Dates ▶ **to ▶**

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 04/2015

Blank copies of this form may be reproduced or downloaded from www.virginiaasthmacoalition.org

Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, and District of Columbia Asthma Partnership