

CELINA ISD HEALTH SERVICES

MEDICATION AUTHORIZATION

STUDENT NAME _____ GRADE _____

1. Medication _____ Dosage _____ Time _____

2. Medication _____ Dosage _____ Time _____

3. Medication _____ Dosage _____ Time _____

Medication will (check one):

_____ stay at school until _____ (give ending date)

_____ will come home daily

Prescription medication must be in the original container with label including date, name of patient, name of medication, dosage and physician's name. Over the counter medications must be in the original container with the student's name on the bottle. Any over the counter medication that is to be given for five (5) or more *consecutive* days, **MUST** have a doctor's signature.

ONCE/TWICE A DAY MEDICATION WILL NOT BE GIVEN DURING SCHOOL HOURS UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THE SCHOOL NURSE.

I understand and agree to the following:

1. I request Celina ISD administer the above named medication to the student named.
2. I authorize the nurse or other designated school personnel to administer the medication to my child according to the prescription or dosage per label directions.
3. I authorize the school nurse to communicate with the physician if needed in order to ensure safe administration of the medication at school.
4. I further give permission for necessary information related to my child's condition to be shared with the school nurse.
5. I understand that narcotics and/or ADD/ADHD medication must be brought to school and picked up by the parent/guardian.

I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS.

PARENT SIGNATURE _____ TODAY'S DATE _____

PHYSICIAN SIGNATURE _____

CELINA INDEPENDENT SCHOOL DISTRICT
Health Services
ASTHMA ACTION PLAN

Student's Name: _____ Grade _____

Dr.: _____ Dr's. Phone #: _____

GREEN ZONE

Your child's asthma is under good control. Avoid triggers that bring on asthma. Take the following medicine as directed to keep asthma under good control. **Peak flow from _____ to _____.**

1. _____ 2. _____

YELLOW ZONE

Your child's asthma is not under good control. Symptoms of asthma may be mild to moderate. You may notice:

Cough especially when sleeping
Congestion / allergy symptoms
Wheezing / mild retractions

Cries easily or grumpy
Dark circles under eyes
Changes in appetite

Peak flow from _____ to _____. Start the following medicine:

1. _____ 2. _____

Call your doctor if child is in this zone for more than one day.

RED ZONE

THIS IS AN EMERGENCY!! Get help...your child's asthma is serious. You may notice symptoms in the yellow zone are getting worse; you may also notice: **Nasal flaring, constant cough, wheezing, skin between ribs pulled tight, unable to talk, cry or play.** **Peak flow from _____ to _____.** Give the following treatment and then **call the doctor or go to the emergency room.**

1. _____ 2. _____

CALL 911 IF CHILD HAS BLUE LIPS, FINGERNAILS, CAN'T WALK OR TALK OR BECOMES LETHARGIC (SLEEPY/DROOPY LOOKING).

Authorization and Disclaimer from parent/guardian: My child may carry and self-administer asthma medications and agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications: _____ Yes _____ No

Parent/Guardian signature

Date

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medication: _____ Yes _____ No (This authorization is for a maximum of one year from doctor's signature date).

Healthcare Provider Signature

Date