WAYNE COUNTY SCHOOLS MEDICATION ADMINISTRATION BY SCHOOL EMPLOYEES (O.R.C. 3313,713) [Note: ALL blanks must be filled in]

Student Name Student's School or class		
Name & Strength of the medication		Asthma Action Plan
		Mild shortness of breath, coughing and wheezing:
Dosage & Route & Time to be admin	istered	1st dose: 2 puffs of Albuterol inhaler or 1 ampule nebulizer as directed. Observe for 20 minutes and return to class if symptoms have improved.
Reason for medication		2 nd dose: If symptoms are still present after 20 minutes repeat quick relief medication as ordered and observe for 20 minutes. Return to class if symptoms have improved.
Date administration is to start & end		3 rd dose: If symptoms are still present after waiting 20 minutes after 2 nd dose, repeat quick relief medication as ordered and call parent & physician's office.
Adverse reactions to report to the phy	sician & special instructions fo	or Administration of medication
For asthma, use asthma action plan as	stated: YES NO	
If applicable: This student received in recommendation that this student carr	struction in the use of the abov y their inhaler on their person	ve inhaler by my trained staff or me. It is my a at all times. Yes No
If applicable: This student received in recommendation that this student carr	nstruction in the use of the abov y their EpiPen on their person	eve EpiPen by my trained staff or me. It is my n at all times. Yes No
Name of Physician	Phone	Date
Signature of Physician		
medication listed above to my child as ins child has taken this medication under my inhaler or EpiPen as prescribed by physici I are aware of the protocols and safety issu. All medication must be brought to physician or pharmacist, clearly labeled. In medication that will be administered during clinic/office or other secure storage area. If any revisions to the above plant.	supervision and has had no negative an on his/her person during school uses at school. The school in the original contain Ask the pharmacist to give you 2 can school hours or school sponsored or prescriber's statement occur, a incipal's designee. It is understook	the principal's designee, to administer the prescribed rized healthcare provider with prescriptive authority. My ive side effects. If applicable, my child may carry his/her ol or school related activities as stated above. My child and iner as dispensed by the authorized healthcare provider, containers if necessary. Send only the amount of red activities. Medications will be kept in the school as written revised prescriber's statement must be submitted of that it is the student's responsibility to seek the fally unable to do so.
Signature of Parent/Guardian	Phone (Home/Wor	rk/Cell) Date
Date received at school:	Īnit	tials