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

_____

Dosage & Route & Time to be administered

_____

Reason for medication

_____

Date administration is to start & end

_____

Asthma Action Plan

Mild shortness of breath, coughing and wheezing:

1st dose: 2 puffs of Albuterol inhaler or 1 ampule nebulized as directed. Observe for 20 minutes and return to class if symptoms have improved.

2nd 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.

3rd dose: If symptoms are still present after waiting 20 minutes after 2nd dose, repeat quick relief medication as ordered and call parent & physician's office.

Adverse reactions to report to the physician & special instructions for Administration of medication

_____

For asthma, use asthma action plan as stated: YES NO

If applicable: This student received instruction in the use of the above inhaler by my trained staff or me. It is my recommendation that this student carry their inhaler on their person at all times. Yes No

If applicable: This student received instruction in the use of the above EpiPen by my trained staff or me. It is my recommendation that this student carry their EpiPen on their person at all times. Yes No

_____ _____
Name of Physician **Phone** **Date**

Signature of Physician _____

I hereby request and give permission to the school nurse, the principal, or the principal's designee, to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or EpiPen as prescribed by physician on his/her person during school or school related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be brought to the school in the original container as dispensed by the authorized healthcare provider, physician or pharmacist, clearly labeled. Ask the pharmacist to give you 2 containers if necessary. Send only the amount of medication that will be administered during school hours or school sponsored activities. Medications will be kept in the school clinic/office or other secure storage area.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the school nurse, the principal or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless s/he is physically or mentally unable to do so.

_____
Signature of Parent/Guardian **Phone (Home/Work/Cell)** **Date**

Date received at school: _____ Initials_____