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 for **current school year only**, 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-4/24

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name:

DOB:

School Year:

Healthcare Provider

Contact Number:

EMERGENCY CONTACT

Name: Phone:

Relationship:

Additional info:

GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

☐ **Daily Maintenance/Controller**

	Day puffs	Night puffs

☐ Montelukast/Singulair ____ Mg once daily.

Use controller daily, even when I feel fine. Use a spacer if recommended.

For Asthma with exercise add: ____ puffs (with spacer if needed) 15 minutes prior to exercise:

_____ And ☐ Ipratropium ☐ Only if needed

YELLOW ZONE: Caution!

- Cough, wheeze, chest tightness
- Waking at night due to asthma
- Problems sleeping, working, or playing

Add: quick-relief medicine—to your GREEN ZONE medicines.

First

Your quick reliever medicine(s) is: _____ or _____

Take: ____ puffs or ☐ Nebulizer every – 20 minutes if needed for up to 1 hour. If your symptoms resolve return to GREEN ZONE.

Second

If your symptoms continue or return within a few hours of above treatment, take:

☐ Puffs every 4-6 hours as needed until symptoms resolve.

☐ Continue every 4-6 hours daily for ____ days.

☐ Add: _____

Call Healthcare Provider if you need quick-relief medicine for more than 24 hours or if quick-relief medicine does not work.

You should not use more than 8 puffs for ages 4-11 or 12 puffs ICS/formoterol for ages 12+ a day.

RED ZONE: DANGER!

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

CALL 911 Now/Go to the Emergency Department!

Continue CONTROL & RELIEVER Medicines every 15 minutes for 3 treatments total – while waiting for help.

Take: _____ ☐ 2 puffs ☐ 4 puffs ☐ 6 puffs or ☐ nebulizer

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: ☐ in clinic or ☐ with student (self-carry).

Parent/Guardian signature _____ Date _____

School Nurse/Staff Signature _____ Date _____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

☐ Student may carry and self-administer inhaler at school.

☐ Student needs assistance & should not self-carry.

MD/NP/PA signature _____ Date _____

Approved June 2023, Virginia Asthma Action Plan Expert Group convened by the Consortium for Infant and Child Health at Eastern Virginia Medical School.

Updated August 2023