Emergency Health Care Plan - Asthma

Physician's Authorization to Administer Medication at School

School Year:_____School:_____Grade: _____

Student: _____Date of Birth: _____

- This student has asthma for which the following medications have been prescribed for treating and preventing emergencies.
- This student has been trained in the use of these medications.
- The staff of Madison Consolidated Schools has permission to give/assist with these medications as needed.

Medication	Dose	Route	Time

Please notify parents if these do not relieve the student's problems

Name of parent: _____ Phone Number:_____
Alternate person to reach if parent is unavailable:_____ Phone Number:_____

_____ This student possess enough skill and maturity to carry the medication/inhaler and use it under the general supervision of school personnel.

_____ This student's medication must be kept by school personnel and administered only with detailed and specific supervision.

_____ This student's condition does not warrant having an inhaler at school except during exacerbation of condition and will be prescribed at that time.

Adverse effect that should be looked for: _____
Potential for abuse or addiction: _____
Comments:
_____
_____

Physician's Name: (Please Print) _____ Date: _____
Physician's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____

PLEASE COMPLETE THE ABOVE PLAN, PARENT & PHYSICIAN & RETURN TO SCHOOL.
According to School Policy and Indiana State Law, this information must be kept on file at school. If you do not have an appointment in the near future, your physician may FAX a note stating the child's diagnoses and medications prescribed.