Saint Ambrose School
Asthma Action Plan and Medication Order

*Please complete this form and return to the school clinic. Asthma medication cannot be administered until current prescription is in clinic and form is completed by parent and physician *

Student Name ___________________________________ Grade ________

Identify the triggers which start an asthma episode:
____
____

Usual asthma symptoms:
____
____

Emergency action is necessary if my child experiences the following symptoms:
____
____

Medication Name: ________________________________ Medication dosage:__________________
Time medication is to be given: _____________________
Date administration begins: _________________________ Date administration ends: _______________
Side effects: ____

Will student keep inhaler in school clinic or self carry? _____________________________**If self-carry, please complete reverse side, complete with parent and physician signature.

In consideration of my child being administered at my request, on behalf of my child: I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, St. Ambrose School and Parish, employees and volunteers from all claims, judgment or liability of any injury or damage due to the designated administration of said medication to my child.

Must be completed by parent:

Parent name (print)	Parent phone number
Parent signature	Date

Must be completed by physician:

Physician name (print)	Physician phone number
Physician signature	Date

SAINT AMBROSE SCHOOL
STUDENT POSESSION AND SELF ADMINISTRATION OF MEDICATION

The additional information requested below must be completed by both the physician who prescribes the medication, and the parent/guardian of the student. This form must then be delivered to the school nurse prior to the student having possession of the medication. **Note:** Student Self-Medication is reserved for those students needing EMERGENCY MEDICATION, such as an inhaler for Asthma or an Epinephrine for Anaphylactic Allergic Reactions.

Must be Completed by Physician for Student to Self-Administer Medication:

Adverse reactions that should be reported to the physician: ____
____
____

Procedure to follow in the event that medication does not produce the expected relief: ____
____
______

Other Special Instructions: ____
____

This patient has been instructed in the proper use of this medication, the expected results, and possible side effects. It is in my professional opinion that he/she is capable of and should be allowed to carry and self-administer this medication.

Physician Name (print):____

Physician Signature:________________________________ Date:______________________

Must be Completed by Parent/Guardian for Student to Self-Administer Medication:

I authorize my child to self-administer the medication described on this form as directed by my child's physician. I also agree to comply with school policy and regulations regarding self-administration of medication. I, also, agree to submit to the building principal/nurse assigned to my child's school building a revised authorization, if any of the information contained in the Physician's Authorization or my authorization changes. I also understand that pursuant of Ohio Revised Code, Section 3316.716, the school and its employees are not liable for my child's self-administration of this medication. I also understand that is my responsibility to review with my child when he/she should come to the office or clinic for additional medical assistance.

Parent Name (print):____

Parent Signature:________________________________ Date:______________________