CLEVELAND METROPOLITAN SCHOOL DISTRICT

Medication Authorization Form for Prescribed Medication

(With Asthma Action Plan)

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

STUDENT INFORMATION		
Student Name	Student's Date of Birth	**For School Use Only**
		Date Received/Receiver's Signature: Medication Received? Yes No
School Name	Lunch Period	Date Approved/Nurse's Signature:
		Entered in RNI? Yes No

MEDICATION INFORMATION			
Medication	Dose	Route	Frequency
Diagnosis/Reason for taking medication			
Start Date	End Date		
Possible side effects:			
Controlled Substance? YES NO			
Special instructions:			
Is student capable and responsible for self-administering this medication? ☐ No Yes (SUPERVISED) Yes (UNSUPERVISED, please complete a self-carry form) ☐ May student carry this medication? YES NO			

PRESCRIBING HEALTH PROFESSIONAL	
Signature	Date
Printed Name	
Phone	Fax

To Be Completed by Parent/Guardian

I give permission for my child, _____, to receive the above medication at school according to the CMSD policy. It is understood that the CMSD and all of its school personnel are absolved from any responsibility, which might be associated with the administration of such medication. It is also understood that by requesting CMSD personnel to administer medication to my child that I also allow the prescriber to communicate with the school nurse regarding my child's treatment plan.

Signature:		Date:
Parent/Guardian Information:	Printed Name:	
	Adress:	
	Home Phone:	Cell Phone:
	Work/Emergency:	Email address

Reviewed by RN	Printed Name:	Date Reviewed:

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Asthma Action Plan

Triggers	❑ Colds ❑ Foods ❑ Weather ❑ Exercise ❑ Other	❑ Air Pollution ❑ Animals ❑ Smoke ❑ Dust
Exercise Pre-Medication:		

Green Zone: Doing Well	Peak Flow Meter Personal Best =		
Symptoms • Breathing is good • No cough or wheeze • Can work and play • Sleep through the night • Peak flow Meter more than 80% of personal best or _____	Mediation(s)	Dosage(s)	How often

Yellow Zone: Getting Worse	Continue Green Zone medicine and add:		
Symptoms • Exposure to known triggers • First signs of cold • Cough • Mild wheeze • Tight chest • Coughing at night • Peak Flow Meter between 50% to 80% of personal best or _____ to _____	Medication(s)	Dosage(s)	How often

Red Zone: Medical Alert	Take these medications		
Symptoms • Medication is not helping • Breathing if hard and fast • Trouble speaking • Cannot work or play • Getting worse instead of better • Peak Flow Meter 0% to 50% of personal best or _____ to _____	Medication(s)	Dosage(s)	How often