CLEVELAND METROPOLITAN SCHOOL DISTRICT
Vision to Victory

PARENTAL REQUEST FORM

FOR PRESCRIBED MEDICATION (with Asthma Action Plan)

Student Name	**aka**	**Student ID**	**Date of Birth**
School Name		**Hours**	**Lunch Period**

Diagnosis/Reason for Medication(s):				
Name of Medication(s):				
Medication Form:	☐ TABLET/CAPSULE	☐ LIQUID	☐ INHALER	☐ INJECTION
	☐ OTHER:			
Special Storage Requirements:	☐ REFRIGERATE	☐ NONE		
	☐ OTHER:			
Start Date:				
Stop Date:	☐ END OF SCHOOL YEAR	☐ FOR EPISODIC/EMERGENCY EVENTS ONLY		
	☐ OTHER/DURATION:			
Instructions: (Schedule and dosage to be given; please include <u>all</u> medications taken daily)	AT SCHOOL:		TIME:	
	AT HOME:		TIME:	
Restrictions/Side Effects:				
Student Responsibility:	Is student capable and responsible for self-administering this medication?			
	☐ NO	☐ YES (SUPERVISED)	☐ YES (UNSUPERVISED)	
	May student carry this medication?	☐ YES	☐ NO	
Additional Information:	Please indicate if you have provided additional information:		☐ YES	☐ NO
	If so, describe:			

Date: _____ **Signature:** _____ *(Authorized Provider)*

Physician Information:	PRINTED NAME:			
	ADDRESS:			
	PHONE #:		EMERGENCY #:	

ASTHMA ACTION PLAN

Triggers:	☐ COLDS	☐ SMOKE	☐ WEATHER	☐ AIR POLLUTION
	☐ FOOD	☐ DUST	☐ EXERCISE	☐ ANIMALS
	☐ OTHER:			
Exercise Pre-Medication: (how much and when)				
Exercise Modifications:				

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[redacted]	Peak Flow Meter Personal Best =	
Symptoms	**Control Medication(s)**	**Dosage(s)**
• Breathing is good • No cough or wheeze • Can work and play • Sleeps all night • Peak Flow Meter more than 80% of personal best or _____		

[redacted]	Continue Control Medications **and add (quick-relief medication)**	
Symptoms	**Medication(s)**	**Dosage(s)**
• Some problems breathing • Cough, wheeze or chest tight • Problems working or playing • Wake at night • Peak Flow Meter between 50% to 80% of personal best or _____ to _____		
	If symptoms (and peak flow if used) return to Green Zone after 1 hour of the quick relief treatment, THEN	**If symptoms (and peak flow if used) *do not* return to the Green Zone after 1 hour of the quick relief treatment THEN**
	☐ Take quick-relief medication every 4 hours for 1 to 2 days ☐ Change long-term control medicines by _____ ☐ Contact your physician for follow up care	☐ Take quick-relief treatment again ☐ Change long-term control medicines by _____ ☐ Call your physician within ____ hours of modifying your medication routine

[redacted]	Control Medications **and add:**	
Symptoms	**Medication(s)**	**Dosage(s)**
• Lots of problems breathing • Cannot work or play • Getting worse instead of better • Medication is not helping • Peak Flow Meter 0% to 50% of personal best or _____ to _____		
	Go to the hospital or call for an ambulance if:	**Call an ambulance immediately if the following danger signs are present**
	1. Still in the red zone after 15 minutes 2. If you are unable to reach the Physician for help	1. Trouble walking/talking due to shortness of breath 2. Lips or fingernails are blue

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. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. 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.

Date: _____ **Signature of Parent/ Guardian:** _____

Parent/Guardian Information:	PRINTED NAME:			
	ADDRESS:			
	HOME PHONE #:		WORK/EMERGENCY #:	

Reviewed by Nurse:	PRINTED NAME:		DATE REVIEWED:	