



VIRGINIA BEACH CITY PUBLIC SCHOOLS

A H E A D O F T H E C U R V E

ANNUAL CONTRACT FOR SELF-ADMINISTRATION OF INHALED MEDICATION FOR ASTHMA

PHYSICIAN OR PRESCRIBER

Name of Student _____ Grade/Room _____

Name of Medication _____

Frequency of Use _____

Duration of Order _____

Health Care Plan or Action Plan, specific for the student is provided for the school. (This plan is required by state code.) Yes _____ No _____

Any directions or comments specific to the student. What is the recommended emergency response? _____

(Physician's signature)

(Phone)

(Date)

.....

PARENT/GUARDIAN

I have provided the school with the orders and health care plan from the physician. I understand that I will not hold the school board or its employees responsible for any negative outcomes from self-administration of the inhaled asthma medication. Further more, I understand that the principal may revoke the permission to possess and self administer inhaled asthma medication for the remainder of the school year, if it is determined that my student is not safely and effectively self-administering the inhaled medication.

(Parent/Guardian's signature)

(Phone)

(Date)

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TO BE COMPLETED BY THE SCHOOL NURSE

SCHOOL NURSE CHECKLIST: Documentation of this agreement is on file in the school clinic.

_____ Prescribed orders _____ Demonstrated ability by the student

_____ Action Plan _____ Parent signature

_____ Emergency Plan _____ Teacher(s) informed

**VIRGINIA BEACH CITY PUBLIC SCHOOLS
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION**

Whenever possible, it is desirable for medication to be scheduled at times other than school hours for the safety of the student. Administration of medication during school hours is discouraged. However, individual needs will be taken into consideration.

Regulations include:

1. Written orders using this form from a physician detailing the name of the drug and the specific information below is required.
2. Using this form, signature of parent or guardian requesting that the school district comply with the physician's order is to be obtained.
3. **Medication must be brought to school by parent or guardian** in a container, appropriately labeled by the pharmacy or physician. Unopened over-the-counter medications can be labeled by the school nurse if all other criteria for administration of the medication has been satisfied.
4. Exact duration for administration of medication must be stated. Date of termination for the medication must be specified. When duration is not specified, medication will be administered for one month (30 calendar days from date of order). **"Indefinite" or "Ongoing" are not acceptable.**

Please fill in and sign this form:

Name of Student _____

Date of Order _____ Diagnosis _____

Name of Medication _____

Dosage _____ Time _____

Specific Duration of Order _____

Is there any anticipated reaction? Yes _____ No _____ Describe _____

If not given, can a serious reaction occur? Yes _____ No _____ Describe _____

Treatment recommended _____

Physician's/Practitioner's/Dentist's Signature **Phone Number**

I request that the school give the above medications as ordered by the physician and I give my permission for the school to contact the physician's office regarding the medication should this be necessary.

Parent's or Guardian's Signature **Phone Number**