

LINCOLN PARK MIDDLE SCHOOL

Asthma Individual Action Plan/Physician Request for Medication Administration in School

STUDENT'S NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN NAME _____ TELEPHONE (H) _____
(W) _____

PHYSICIAN'S NAME (please print) _____ TELEPHONE _____

ADDRESS _____

THE FOLLOWING PROCEDURE(S) SHOULD BE FOLLOWED IN THE EVENT OF AN ASTHMA ATTACK:

THE FOLLOWING MEDICATIONS SHOULD BE ADMINISTERED BY THE SCHOOL NURSE TO THE ABOVE NAMED STUDENT:

NAME OF MEDICATION _____

DOSAGE VIA INHALER _____

CIRCUMSTANCE UNDER WHICH MEDICATION SHALL BE ADMINISTERED VIA NEBULIZER:

NAME OF MEDICATION _____

DOSAGE VIA NEBULIZER _____

POSSIBLE SIDE EFFECTS AND/OR SPECIAL PRECAUTIONS TO BE TAKEN _____

Conditions under which self-medication will take place:

_____ Independently The child has been trained and is proficient in self-administering of medication via the metered dose inhaler (MDI).

_____ Under the supervision of the school nurse

Medication should be _____ in the possession of the student
_____ stored in the health office

PHYSICIAN'S SIGNATURE _____ DATE _____

I give my permission for my child to self-administer the medication described above. I understand and acknowledge that the Board of Education, collectively and individually, as well as its employees or agents shall incur no liability whatsoever as a result of any injury, whether foreseen or unforeseen, arising from the self-administration of medication by my child. I also agree to indemnify and hold harmless the Board of Education, collectively and individually, as well as its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising from any claims brought by the above-named child, individually or by a guardian, or anyone else.

PARENT/GUARDIAN SIGNATURE _____ DATE _____