



Radiant
STEM Academy

MEDICATION CONSENT FORM

Everyone Is An Achiever

** Medication Consent Forms are subject to change*



STUDENT MEDICATION REQUEST

Date: _____ Student Name: _____

Allergies: _____

Teacher: _____ Grade: _____ DOB: _____

Name of Doctor Prescribing the Medication: _____ Phone No: _____

I request school personnel to administer the medication listed below to my child. With my signature below, I also give permission to the school staff to contact the health care provider for additional information.

Medication:

Duration : _____ All year _____ Number of days _____ As needed

Name of Medication	Dosage	Time to be administered

Reason for medication: _____

Possible side effects: _____

Medication allergies, if any: _____

Special Instructions: _____

Signature of Parent/Guardian: _____ Relationship to student: _____

PLEASE NOTE : See medication guidelines below.

Medication Administration guidelines:

- Medication should be in its original, properly labelled container. The parent is responsible for informing the school about any change in medication. If dosage changes, a new properly labelled container and/or the healthcare provider's written instructions must be provided.
- Initial dose of any medication must be given by parent at home prior to requesting administration at school and effects of medication reported to school personnel.
- No more than 15 doses of the medication will be accepted, except in case of chronic conditions. Any unused medication not picked up by the end of school year will be destroyed.
- If tablets are to be administered in portions, parents are required to cut the tablets before handing it over to the school personnel.
- Subject to healthcare providers written instructions stating it is necessary to be given at school or during school related activities, school personnel will not administer herbal supplements to students.
- Although every effort will be made to make sure that the medication is given in a timely manner, RSA personnel is not responsible for any missed dosages not given because of absence or student refusal.



Asthma Action Plan must be renewed each academic year

It is required that parents provide Peak Flow Meter if requesting to monitor peak flow number

Date:	Name:	DOB:
Parent/Guardian	Parent/Guardian Phone Number	Healthcare Provider's Name/Phone #
Medications to take at school include:		
Name of Medication	Dose	When to Use

This action plan has been individually designed to help school professionals assist this student in controlling and treating asthma at school. It is based on monitoring asthma symptoms and may also be based on peak flow numbers.

<p>Green Zone Personal Best Peak Flow _____ Date: _____ Peak flow is between _____ (80% of personal best) and _____ (100% of personal best) Use these interventions: _____</p>
<p>Yellow Zone If peak flow number is from _____ to _____ or you notice any of these symptoms: Use these interventions: _____ _____</p>
<p>Red Zone If peak flow number is from _____ to _____ or you notice any of these symptoms: Use these interventions: _____ _____</p>

Other Instructions:

Healthcare Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

Physician Signature/Date:

Parent Signature/Date:

Reviewed by Administrator: _____ **Date:** _____



Asthma History

Date:	Student's Name:
Grade:	DOB:
_____ No _____ Yes	
Has your child ever been diagnosed by a physician or hospitalized for asthma?	
If yes, name of physician treating child's asthma:	
Physician's phone #	
Approximately how often does your child have an asthma attack?	
What are the signs and symptoms of your student's asthma attack, including early signs?	
When was the last attack?	
What triggers your child's asthma or makes it worse?	
_____ No _____ Yes (If yes, please explain.)	
Does exercise cause an asthma attack?	
_____ No _____ Yes (If yes, please explain.)	
Does weather affect your child's asthma?	
What are your child's asthma symptoms?	
Name the medication(s) taken routinely, the dosage, and how often they are to be taken by your child in school?	
_____ No _____ Yes (If yes, please explain.)	
Does your child have side effects from these medications?	
_____ No _____ Yes	
Does your child usually use a spacer or holding chamber with his/her metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)?	
_____ No _____ Yes (If yes, please explain.)	
Does your child understand asthma and what he/she should do to manage the condition?	
_____ No _____ Yes. If yes, what is your child's personal best peak flow number? _____ Provide the peak flow meter to school.	
Does your child use a peak flow meter (something he/she blows into to check his/her airway)?	

Comments:

Parent/Guardian Name:

Parent/Guardian Signature/Date:

Reviewed by Administrator: _____ **Date:** _____



Permit for Self-Administration of Asthma Medication

This authorization must be renewed each academic year

(TO BE COMPLETED BY PHYSICIAN)

Child's Name: _____

Note: Radiant Stem Academy will permit the self-administration of asthma or epinephrine medication to Middle school students upon completion of this form. If at any time the safety of this child or others is at question and the problem cannot be resolved satisfactorily, RSA may revoke this student privilege.

Date _____

This child is under my care for the treatment of _____ and will require the below listed prescription medication at school and at school related events. I have instructed the above named child in the proper way to use his/her medication and he/she has demonstrated the skill necessary to self-administer the medication. It is my professional opinion this child should be allowed to carry and use the medication listed below by himself/ herself.

Name of Drug	Dosage	Frequency	Time to Be Given at School	Duration	Side Effects

Note: This authorization is valid through the end of the current academic year unless superseded by another written physician's authorization.

Signature of Physician: _____

Printed Name of Physician: _____

Physician Address: _____

Physician Telephone Number: _____

Emergency Telephone Number: _____