



ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2025-2026

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____
 Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____
 School (include: ATS DBN/Name, address, and borough): _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis

☐ Asthma
☐ Other: _____

Control (see NAEPP Guidelines)

☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

Severity (see NAEPP Guidelines)

☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent
☐ Unknown

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	
History of asthma-related PICU admissions (ever)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	
Received oral steroids within past 12 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	_____ times last: _____
History of asthma-related ER visits within past 12 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	_____ times last: _____
History of asthma-related hospitalizations within past 12 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	_____ times last: _____
History of food allergy or eczema, specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	
Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	

Home Medications (include over the counter) ☐ None

☐ Reliever: _____ ☐ Controller: _____ ☐ Other: _____

Student Skill Level (select the most appropriate option):

- ☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer
☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school-sponsored events. Practitioner's Initials: _____

Quick Relief In-School Medication

Individual spacers are provided by the school. Schools will only provide Albuterol MDI and Fluticasone 110 ucg

Emergency Plan: If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!

Standard Albuterol Order: Albuterol: Give 2 puffs Q4 prn cough, wheezing, difficulty breathing, chest tightness or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.

☐ Pre-exercise: Name: _____ Dose: _____ puffs/ _____ AMP 15-20 mins before exercise.

☐ URI Symptoms/Recent Asthma Flare:

Name: _____ Dose: _____ puffs/ _____ AMP q _____ hrs for _____ days when directed by PCP

Other Quick Relief Medication instead of Standard Albuterol Order: SMART/MART (ginasthma.org)

Administer medication for respiratory symptoms: cough, wheezing, difficulty breathing, chest tightness, or shortness of breath; if not symptom-free in 20 minutes, may repeat ONCE.

The Standard Albuterol Order will be implemented if medication prescribed below is unavailable.

- ☐ Budesonide/formoterol (provided by parent): Strength: _____ Dose: ☐ 1 puff ☐ 2 puffs every 4 hours PRN respiratory symptoms.
☐ Albuterol with ICS: Albuterol 2 puffs plus Fluticasone 110 ucg 1 puff every 4 hours PRN respiratory symptoms.
☐ Albuterol with ICS: Albuterol: 2 puffs plus Fluticasone 110 ucg _____ puffs every 4 hours PRN respiratory symptoms.
☐ Albuterol _____ puffs + ICS (provided by parent) Name: _____ Strength: _____: _____ puffs every 4 hours PRN respiratory symptoms.

Special Instructions:

Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

Stock Fluticasone 110 mcg will be used if prescribed medication below is not available.

- ☐ Fluticasone [Only Fluticasone® 110 mcg MDI is provided by school for shared usage] ☐ Stock ☐ Parent Provided
 Standing Daily Dose: _____ puff (s) ☐ one **OR** ☐ two time(s) a day Time: _____ AM and _____ PM
☐ Budesonide/formoterol (provided by parent). Standing Daily Dose: _____ puff (s) ☐ one **OR** ☐ two time(s) a day Time: _____ AM and _____ PM
 Special Instructions: _____
☐ Other ICS (provided by parent) Standing Daily Dose:
 Name: _____ Strength: _____ Dose: _____ Route: _____ Frequency: ☐ one **OR** ☐ two time(s) a day Time: _____ AM & _____ PM

Health Care Practitioner

Last Name (Print): _____ First Name (Print): _____ ☐ MD ☐ DO ☐ NP ☐ PA
 Signature: _____ Date: _____ NYS License # (Required): _____ NPI #: _____
 Completed by Emergency Department Medical Practitioner: ☐ Yes ☐ No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)
 Address: _____ E-mail address: _____
 Tel: _____ FAX: _____ Cell Phone: _____

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

FORMS CANNOT BE COMPLETED BY A RESIDENT

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS.

PARENTS MUST SIGN PAGE 2 →

| REV 6/25

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Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
- I understand that:
 - I must give the school nurse/School Based Health Center (SBHC) my child's medicine and equipment, including non-albuterol inhalers.
 - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
 - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
 - I certify/confirm that I have checked with my child's health care practitioner and I consent to the Office of School Health (OSH) giving my child stock medication in the event my child's asthma medicine is not available.
 - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the doctor's instructions.
 - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
 - By signing this medication administration form (MAF), I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
 - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier).
 - When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse/SBHC stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through the OSH medical team. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
 - This form represents my consent and request for the asthma services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
 - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved medications with your child for a school trip day and/or an after school program. Stock medications are only for use in school by OSH staff.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse/SBHC will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Parent/Guardian Cell Phone: _____ Other Phone: _____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone: _____

For Office of School Health (OSH) Use Only

OSIS Number: _____ Received by - Name: _____ Date: _____

☐ 504 ☐ IEP ☐ Other _____ Reviewed by - Name: _____ Date: _____

Referred to School 504 Coordinator: ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only)
☐ School Based Health Center ☐ OSH Asthma Case Manager (For supervised students only)

Signature and Title (RN OR MD/DO/NP): _____

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified