FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT

NEBULIZER AUTHORIZATION FORM

This order is valid only for the current school year_____ (Including Summer Session)
OR
Start Date: ____/____/_____ to Stop Date: _____/____/____

This treatment authorization form must be completed fully in order for staff to administer required treatment. A new form must be completed at the beginning of each school year.

- Carefully review the reverse side of this form before completion

Name:	***Date of Birth:***	***Grade:***

HEALTH CARE PROVIDER AUTHORIZATION

Allergies:

Condition for which treatment is being administered:

Type:	**Dose:**	**Route:**
Name of Medication:_____		Inhalation

Administer Treatment:

- ☐ For symptoms such as: *coughing, audible wheezing, complaint of tightness in chest, complaint of shortness of breath, and/or other*_____.
- ☐ At parent / guardian's discretion.

Time of Administration:	***If PRN, frequency:***

Additional instructions:

Is student competent to self-administer treatment?
☐ Yes ☐ No

Health Care Provider Stamp

Health Care Provider's Name/Title: (Please Print)

Telephone:	Fax:

Address:

Health Care Provider's Signature: ***Date:***

PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the treatment as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of treatment at school and understand that the health care provider will be contacted if questions arise regarding the student's treatment order.

Primary Contact Phone:	***2nd Phone:***

Parent/Guardian Signature:

REGISTERED NURSE REVIEW / AUTHORIZATION

Is student competent to self-administer treatment?
☐ Yes ☐ No

Registered Nurse Signature: ***Date:***

IMPORTANT INFORMATION
for Parents/Guardians and Health Care Providers

1. Please give your child any needed treatment at home if at all possible.

2. It is recommended that the first full day's (24 hours) treatment be given at home. If unsure, follow the recommendation of the health care provider about attending school during the first 24 hours.

3. Medication:
   a. Prescription medication(s) must be in a container labeled by the pharmacist with the student's name, prescriber's name, name of medication, dosage, route, directions for administration, conditions for storage, prescription date and expiration date. *Maryland law allows prescription medication to be used only for 1 year beyond date of issue or expiration date indicated on the medication—whichever comes first.*

4. In the event the student requires the treatment during a field trip:
   a. The nebulizer must be battery operated, ***or***
   b. An alternate prescribed medication (i.e. inhaler) may be substituted. This alternate medication will require a *Medication Authorization* form.

5. Parent/guardian responsibilities:
   a. Provide and maintain all equipment and supplies for the duration of the treatment order.
   b. Provide a new medication prior to the expiration date on the pharmacy label.
   c. Bring the medication to school. FCPS regulation 400-23 states that students are not permitted to transport medications, unless authorized to self-carry.
   d. Retrieve any unused or discontinued medication(s). No medications will be sent home with students.

6. The parent/guardian or student may demonstrate how to administer the treatment to the staff person who will monitor or administer the treatment and provide information regarding potential adverse effects.

7. Student Self-Administer:

   a. The health care provider and registered nurse must indicate whether the student is competent to self- administer, if needed.
   b. If competent to self-administer, the registered nurse will work with the student and parent/guardian to develop a *Plan for Medication/Treatment Management Outside the Health Room.*

8. The registered nurse must review and approve this form prior to administration.