

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**1. DIAGNOSIS: Please list all diagnoses and medications. Please indicate if medications will be given at school or at home.**

Diagnosis

Medications:	Dose:	Route:	Frequency:	Comments

**2. Please complete if child has asthma. Leave area blank if child does not have asthma diagnosis:**

Asthma: \_\_\_\_\_ ☐ Mild ☐ Moderate ☐ Severe

a. History of Exercise induced Asthma: ☐ Mild ☐ Moderate ☐ Severe

**\*\*If child has asthma, please complete information below and include Asthma Care Plan:**

**PRN:** Albuterol MDI 2 puffs and/or Albuterol 2.5mg nebulizer premix vials ☐ Yes ☐ No Or

\_\_\_\_\_

Pretreatment for exercise: Albuterol MDI 2 puffs or ☐ Yes ☐ No ☐ PRN

\_\_\_\_\_

**3. Allergies (Food Allergies please include a Allergy/Anaphylaxis Emergency Care Plan)**

**4. Medical adherence issues?**

- I prescribe that the medications are to be given as listed.
- I prescribe that the inhaled medications be used with an appropriate spacer.
- I agree that the student may receive a dose of Acetaminophen based on the student's weight once a day PRN pain or fever over 101 F.
- I agree that the student may receive a dose of liquid antacid 10-30cc Q day PRN indigestion.
- I agree that the student may receive a dose of cetirizine 5-10mg based on age PRN allergic

reaction.

- I prescribe that the student may complete a normal saline nasal/sinus rinse PRN.
- I support the placement at Morgridge Academy due to ongoing medical needs throughout the day
- I recommend a flu shot.

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Providers Phone Number Provider's Name (please print) Date

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Provider's Fax Number Provider's Signature Address