

CITY OF BALTIMORE

STEPHANIE RAWLINGS-BLAKE, Mayor



HEALTH DEPARTMENT

OXIRIS BARBOT, M.D., Commissioner  
1001 E. Fayette Street  
Baltimore, Maryland 21202

June 1, 2011

Dear Health Care Provider:

Regular school attendance is critical to a child's educational success and future as a healthy and productive member of our community. Asthma is the leading cause of school absenteeism, and the third leading cause of childhood disability in the United States.<sup>1</sup> Baltimore City has the highest pediatric asthma hospitalization rate in the state and one of the highest in the nation.<sup>2</sup>

The Baltimore City Health Department's Bureau of School Health is committed to partnering with you and your patients' parents to support your efforts to maximize your patients' asthma control. This partnership is critical to ensuring that all students receive asthma care consistent with national practice guidelines and are ready to learn.

As part of citywide efforts through *Healthy Baltimore 2015*, please consider the summary of national practice guidelines for optimizing asthma control:

- Inform the school nurse that a student has asthma and its severity.
- Prescribe rescue inhalers and spacers to be kept in the health suite
- Complete an asthma action plan to be shared with the child's school nurse at the beginning of the school year
- Prescribe inhaled corticosteroids if the child has persistent asthma and or if asthma symptoms are poorly controlled.

For your convenience we have attached a copy of the *Request to Administer Medication in Schools* form (SH-7), which is to be completed for all students who require medication at school. If you have a patient who is unable to use a spacer or requires nebulizer treatments in addition to a rescue inhaler, please also complete a *Request to Administer Treatment in Schools* form (SH-98). Additional copies of these forms may be downloaded from the Health Department's website at <http://www.baltimorehealth.org/schoolhealth.html>

We look forward to partnering with you in keeping our children healthy and in school, ready to learn.

Sincerely,

Oxiris Barbot, M.D.  
Commissioner of Health

1. Centers for Disease Control. 2009. Asthma. Available at <http://www.cdc.gov/healthyyouth/asthma/index.htm>. Retrieved May 2011
2. Maryland Department of Health and Mental Hygiene. 2008. Available at [http://fha.maryland.gov/pdf/mch/asthma\\_control/AsthmaReport2008.pdf](http://fha.maryland.gov/pdf/mch/asthma_control/AsthmaReport2008.pdf). Retrieved on May 17, 2011.
3. National Heart, Lung and Blood Institute. 2007 Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007. Available at <http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.htm>. Retrieved May 2011
4. Centers for Disease Control. 2011. Asthma in the US. Available at <http://www.cdc.gov/vitalsigns/index.html>. Retrieved May 2011

**MARYLAND STATE  
BALTIMORE CITY HEALTH DEPARTMENT  
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM**

This order is valid only for the (current) school year \_\_\_\_\_ Including the summer session.

School: \_\_\_\_\_

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by a pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring in the medication to the school.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication

**PRESCRIBER'S AUTHORIZATION**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Time(s) In School \_\_\_\_\_

PRN \_\_\_\_\_ frequency: \_\_\_\_\_ for what symptoms? \_\_\_\_\_

Relevant side effects:  None expected  Specify: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Prescriber's Name/title: \_\_\_\_\_

(Type or print)

Office #: \_\_\_\_\_ FAX \_\_\_\_\_

Address: \_\_\_\_\_

(Use for Prescriber's Address Stamp)

Prescriber's Signature: \_\_\_\_\_

(Original signature or signature stamp ONLY)

A verbal order was taken by the school RN Name: \_\_\_\_\_ for the above medication on (Date): \_\_\_\_\_

**Discontinue Medication (signature): \_\_\_\_\_ Date: \_\_\_\_\_**

**PARENT/GUARDIAN AUTHORIZATION**

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

**SELF CARRY/ SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

Self carry/ self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self-carry/self administration of emergency medication: \_\_\_\_\_

Signature Date

School RN approval for self-carry/self administration of emergency medication: \_\_\_\_\_

Signature Date

Date received in health suite: \_\_\_\_\_ by: \_\_\_\_\_

Order reviewed by school RN: \_\_\_\_\_ Date: \_\_\_\_\_



**To Parent/Guardian: To request treatment at school please note:**

This form must be completed and signed by you and your child's medical provider.  
 Complete one form per treatment. A new form is needed for any treatment change or time of  
 treatment change.  
 The medical provider is asked to provide a detailed description of the treatment. Including  
 medication required.  
 It is the responsibility of the family to provide all treatment related equipment and supplies.  
 Treatments will be performed according to standard nursing practice.

Medical Provider's Order for Treatment in School		
Student _____	DOB _____	School _____
Treatment _____		
Equipment to be Used With Treatment:		
_____	_____	_____
_____	_____	_____
Description of Treatment to be Administered:		
_____		
_____		
_____		
_____		
Medication (s) _____	Strength _____	
Dose _____	Route _____	Time(s) _____
Treatment should begin _____ (date) and terminate _____ end of school year		
_____ other-DATE _____		
Medical Provider's Name (please print) _____		Date _____
Medical Provider's Signature _____		Telephone _____
Address _____		Fax # _____

I request and authorize health staff from the Baltimore City Health Department, School Health Program to administer treatment in accordance with the above medical provider's order. In so doing, I agree not to hold the Baltimore City Health Department staff responsible for any ill effects resulting from the administration of this treatment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Parent Phone # \_\_\_\_\_ Emergency Phone # \_\_\_\_\_

Form received by health staff on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Received & Reviewed by \_\_\_\_\_, R.N./L.P.N. on \_\_\_\_/\_\_\_\_/\_\_\_\_