

**CONSENT FORM FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION DURING SCHOOL DAY
TO BE RENEWED EACH SCHOOL YEAR**

(If you need assistance completing this form, contact the Licensed School Nurse)

****Before medication can be administered by school personnel this form must be completed and on file with the school health office****

Student Name _____ Birth Date _____

School _____ Grade _____ Teacher _____ School Year _____

PHYSICIAN / LICENSED PRESCRIBER ORDER

Medication: Epinephrine auto-injector type: _____ Dose: 0.15 mg IM 0.3 mg IM

Instructions for giving medication: _____

Criteria for repeat dosing: _____

Possible side effects: _____

Other/Additional Directions: _____

Emergency Allergy Medication should be administered for the following type(s) of symptoms:

MOUTH SKIN GUT THROAT LUNGS HEART OTHER



itching & swelling of the lips, tongue, or mouth

hives over body, widespread redness, itchy

nausea, abdominal cramps, vomiting, diarrhea

tight or hoarse throat, trouble breathing or swallowing

shortness of breath, wheezing, repetitive cough

pale or bluish skin, faintness, weak pulse, dizziness

feeling something bad is about to happen, anxiety, confusion

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

This student has received instruction and permission to self carry and independently manage: YES NO

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: _____ DATE: _____

PRINT NAME: _____ Clinic _____ Phone #: _____ Fax # _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during regular school hours as ordered by the physician/licensed prescriber.
2. I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. I will provide this medication in the original, properly labeled pharmacy container.
4. I authorize the Licensed School Nurse/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
5. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my child.
6. I release school personnel from any liability in relation to the administration of this medication at school.
7. I have read and understand the Medication Guidelines included with this form.

Parent/Guardian Signature: _____ **Date:** _____

LICENSED SCHOOL NURSE SIGNATURE: _____ **Date:** _____

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without it. Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, after school, and bedtime. **If a new medication is started, the first dose must be given at home, unless it is a rescue medication.**

1. Administration of prescription and non-prescription medication by school personnel must only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian and Licensed School Nurse, regardless of the student's age.
 - a. Mixed dosages in a single container will not be accepted for administration at school.
 - b. If a half tablet is required for a correct dosage, it is the parent/guardian's responsibility to provide pre-cut tablets for administration at school.
 - c. Altered forms of medication will not be accepted or administered at school.
 - d. Narcotics/medical cannabis will not be administered at school.
 - e. Aspirin-containing products will not be administered at school.
 - f. Only FDA approved treatments will be provided at school.
2. **All medication (prescription and non-prescription) must be brought to and from school by a parent/guardian in its original container.** The following information must be on the prescribed container label:
 - a. Student's full name
 - b. Name and dosage of medication
 - c. Time and directions for administration at school
 - d. Physician/licensed prescriber's name
 - e. Date (must be current)
3. New consent forms with licensed health care provider and parent/guardian signatures must be received each school year.
4. A new medication consent form is required when the medication dosage or time of administration is changed.
5. When a long term daily medication is stopped, a written physician/licensed prescriber's order is requested.
6. Medication will be kept in a locked cabinet in the health office unless authorized by the Licensed School Nurse, and must not be carried by the student.
7. Students with severe allergies who need their epinephrine auto-injector during the school day will be allowed to self-manage, carry, and be responsible for the administration of their epinephrine auto-injector with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the Licensed School Nurse.
8. Students with asthma who need to use their inhaler during the school day will be allowed to self-manage, carry, and be responsible for the administration of their inhaler with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the Licensed School Nurse.
9. Secondary students may carry and use **non-prescription** medication with written consent of their physician/licensed prescriber, parent/guardian, signature of student agreement, and with the consent of the Licensed School Nurse. This applies to all secondary students, regardless of age. This medication cannot contain ephedrine, pseudoephedrine, aspirin or medical cannabis. Special arrangements must be made with the Licensed School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.