

ANNE ARUNDEL COUNTY
SCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student: _____ D.O.B: ____/____/____
(LAST) (FIRST) (MI)

Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order **fully** completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
 - *Name of child.* *Name of the medication.* *Dosage, route and time of administration.*
 - *Name of physician.* *Prescription date and expiration date.* *Conditions for proper storage.*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for epinephrine auto-injector) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

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

Relationship to student _____

Phone Number: (H) _____ (W) _____ Other _____

Address: _____

**PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
ONE MEDICATION PER FORM**

Diagnosis: _____

Name of Medication: _____

Dosage: _____ (mg, ml, ml/tsp, # of puffs)

Route: _____ Time of Administration at School: _____ Lunchtime

If PRN, for what symptoms? _____ How Often? _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

Student medication allergies: None Known _____

Services from the beginning to the end of school year **OR**

Services should begin (Date) _____ and terminate (Date) _____ .

FOR INHALER, EPINEPHRINE AUTO-INJECTOR, AND INSULIN ONLY:

_____ It has been determined that this student is able to self-administer and carry inhalant medication or epinephrine auto-injector and has been trained in its use, including knowing when the medication is to be used.

_____ It has been determined that this student is able to self-administer insulin.

_____ This student should not self-administer inhalant medication, insulin, or epinephrine auto-injector.

 **Physician's Signature:** _____ **Date:** _____

Original signature/NO stamps

Physician's Name (Printed): _____

Address: _____

Telephone Number: _____

Order and MAR Reviewed _____ R.N. Date _____

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)



CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? No Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger: But is <i>not</i> exhibiting or complaining of any symptoms	Give this Medication	
	Epinephrine	Antihistamine
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.

*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication	Dose:
Epinephrine:	
Antihistamine:	
Other:	

Doctor's Signature

Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: _____

Phone Number: _____

Contact(s)	Name/Relationship	Phone Number(s)	
		Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

***EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.**

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] yes No

Parent/Guardian's Signature

Date

Maryland State Child Care/Nursery School
 Asthma Medication Administration Authorization Form
 ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (not to exceed 12 months)



Triggers (list)

Student's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

ASTHMA SEVERITY: Exercise Induced Intermittent Mild Persistent Moderate Persistent Severe Persistent

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated					
CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	<input type="checkbox"/> Breathing is good	Medication	Dose	Route	Frequency
	<input type="checkbox"/> No cough or wheeze				
	<input type="checkbox"/> Can work, exercise, play				
	<input type="checkbox"/> Other: _____				
<input type="checkbox"/> Peak flow greater than _____ (80% personal best)					
<input type="checkbox"/> Prior to exercise/sports/ physical education	(Rescue Medication)				
If using more than twice per week for exercise, notify the health care provider and parent/guardian.					
YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms					
CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	<input type="checkbox"/> Cough or cold symptoms	Medication	Dose	Route	Frequency
	<input type="checkbox"/> Wheezing				
	<input type="checkbox"/> Tight chest or shortness of breath				
	<input type="checkbox"/> Cough at night				
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)					
If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.					
RED ZONE: Emergency Medications — Take these medications and call 911					
CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	<input type="checkbox"/> Medication is not helping within 15-20 mins	Medication	Dose	Route	Frequency
	<input type="checkbox"/> Breathing is hard and fast				
	<input type="checkbox"/> Nasal flaring or skin retracts between ribs				
	<input type="checkbox"/> Lips or fingernails blue				
<input type="checkbox"/> Trouble walking or talking					
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Peak flow less than _____ (50% personal best)	Contact the parent/guardian after calling 911.				

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children] Yes No

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____