See the following pages for exhibits relating to medical treatment:

Exhibit A: Medication Administration Request Form and Guidelines for Administration of Medication at School (Parent and Student's Physician Complete – kept on file in Campus Health Clinic) – 1 page

Exhibit B: Medication Administration Skill Checklist (to be accompanied by daily medication log for applicable students) – 1 page

Exhibit C: Medical Orders for Specialized Health Care Procedures (Physician and Parent Complete – kept on file in Campus Health Clinic) – 1 page

Exhibit D: Emergency Health Care Plan (Physician and Parent Complete – kept on file in Campus Health Clinic) – 2 pages

Exhibit E: Self-Administration of Asthma Medicine (Physician and Parent Complete – kept on file in Campus Health Clinic) – 1 page

Exhibit F: Severe Food Allergy (Student Permission for Placement at Designated Table/Area – 1 page

EXHIBIT A

Northwest Independent School District

Medication Administration Request Form
Guidelines for Administration of Medication at School

All medication should be given outside of school hours, if possible. Only medication that is required to enable a student to stay in school may be given at school. Medications ordered three times a day can be given before school, after school, and at bedtime. The initial dose of medication must be administered at home, doctor's office, or hospital. If medication is to be administered at school the following conditions must be met:

1. All medication (prescription and over-the-counter) must be:
   a. provided by the parent/guardian.
   b. transported by an adult if it is a controlled substance, i.e. Ritalin. Controlled medications will be counted upon arrival in the clinic.
   c. in its original properly labeled container. The pharmacy can supply two (2) labeled bottles for this purpose.
   d. accompanied by a written request signed by the parent/guardian to give the medicine.
   e. placed in a locked cabinet in the clinic (exception for asthma inhalers if self administration form is completed).
   f. ordered by a physician if it is to be given longer than 10 days or 10 doses, whichever is longer.
   g. administered by a district employee.
   h. picked up at the health clinic by parent or legal guardian by the end of the school year. Otherwise it will be destroyed.
2. Sample prescription and alternative medicine must be labeled with the child's name and accompanied by a signed physician's order. When ordered, alternative medication must be accompanied by a patient information sheet listing the ingredients, actions, and side effects. Dietary supplements and other nutritional aids not approved as medication by the FDA may not be dispensed by school personnel.
3. The District can assume no responsibility for loss or negligent behavior when the student carries his/her conventional or alternative medication or dietary supplement without the knowledge of the campus health coordinator. **Noncompliance may subject the student to disciplinary action.**
4. The campus health coordinator must be consulted for long term medication, any health care procedure, or monitoring.

1) Start Date	**Name of Medication/Amount Provided**	**Strength (i.e. 10 mg)**	**Dosage (i.e. 2 tabs, 1 tsp.)**	**Time to be Given**
Date/Time/Initials – Clinic Use Only:				

2) Start Date	**Name of Medication/Amount Provided**	**Strength (i.e. 10 mg)**	**Dosage (i.e. 2 tabs, 1 tsp.)**	**Time to be Given**
Date/Time/Initials – Clinic Use Only:				

3) Start Date	**Name of Medication/Amount Provided**	**Strength (i.e. 10 mg)**	**Dosage (i.e. 2 tabs, 1 tsp.)**	**Time to be Given**
Date/Time/Initials – Clinic Use Only:				

Staff Signatures/Initials: _____ _____ _____

Student Name _____DOB_____ Grade _____ Teacher/Homeroom _____
Physician: Printed Physician Name _____ Physician Signature _____
Office Phone _____Fax_____ Date _____

Parent/Guardian:
I give permission for the above medication(s) to be administered to my child at school. I understand that the District, the Board, and its employees are not liable for damages or injuries resulting from administration of medication to my child in accordance with Texas Education Code 21.905.
Parent/Guardian Signature _____ Relationship _____Date_____
Home Phone_____ Work Phone _____Cell Phone_____

Withdraw Date_____ Parent Signature_____

EXHIBIT B

Northwest Independent School District

Medication Administration Skills Checklist

Staff Member_____ Campus _____

Purpose of Training _____ Campus Health Coordinator _____

Criteria	Instructor Initials/date	Staff Initials/date	Comments
Checks written authorization: 1. Verifies MPF signed by Parent and/or Dr. Signature if needed 2. Verifies correct Date, Time and Medication listed on MPF per NISD medication policy			
Demonstrates procedure for giving oral medication: 1. Washes hands 2. Checks label instructions • Rx labeled for student • OTC meds age appropriate in original container Compares with Medication Permission Form 3. Prepares without touching medication 4. Double checks medication and label 5. Identifies child / Asks child to state name 6. States / Follows 5 Rights: • *the right patient* • *the right drug* • *the right dose* • *the right route* • *the right time* 7. Observes child taking medication 8. Documents medication administration 9. Triple checks label and returns medication to locked storage area			
Additional Medication Procedures Demonstrated:			
☐ INHALERS / NEBULIZERS – describes procedure			
☐ EYE / EAR DROPS – describes procedure			
☐ TOPICAL – describes procedure			
☐ EPI-PEN - demonstrated with trainer			
☐ RECTAL (example: Diazepam) – describes procedure			
☐ TUBE FEEDING / MEDICATION - observation with student			
☐ DIABETIC MEDICATION TRAINING* - observation with student			
☐ OTHER:			
Correctly Documents Medication Administration in Med Log			
Identifies Procedure for Medication Errors			

I have completed the NISD Medication Administration by Non-Licensed Staff eCourse YES NO

I have completed the NISD Blood Borne Pathogen Training eCourse YES NO

I have current certification for CPR and First Aid YES NO

I have completed the NISD Diabetic Medication Administration Training* YES NO

I understand that Student Health Information including Medication use is confidential YES NO

Staff Member Signature _____ Date _____

The above named staff member, designated by the campus principal, completed the required NISD Medication Administration training for Non-Licensed Staff as indicated.

Campus Health Coordinator Signature _____ Date_____

EXHIBIT C

Northwest Independent School District

MEDICAL ORDERS FOR SPECIALIZED HEALTH CARE PROCEDURES

Student:	Grade:	Campus:
Physical Condition(s) for which the specialized procedure is to be done:		
Name/Description of specialized procedure:		
Precautions, complications, and needed actions:		
Person(s) authorized to provide procedure: (check all that apply) _____ RN _____ LVN _____ Health Care Assistant _____ Trained School Staff _____ Student		
Time schedule and/or indications for the procedure:		
End date of procedure (maximum is one school year):		
Goal of procedure:		
Estimated time: _____ hours per week		

Parent/Guardian:
I request that this procedure/treatment be performed at school with the above named student. We have reviewed the procedure, its purpose and possible complications with our physician.

Parent/Guardian Signature:	Daytime Number Phone:	Date:
Student Signature (if applicable):		Date:

Physician:

Printed Name of Physician:	Physicians Signature:		Date:
Physician Address:		Phone Number:	Fax Number:

Campus Health Coordinator:

I have reviewed the order for safe implementation. Review/renewal Date:	
Campus Health Coordinator Signature:	Date:

Principal:

I have accepted the order to be carried out by: *(circle)* [Campus Health Coordinator – HCA - School Staff - Student] at school.	
Principal Signature	Date:

EXHIBIT D

Northwest Independent School District

Emergency Health Care Plan

Student Picture

EMERGENCY HEALTH CARE PLAN **CAMPUS**_____ **YEAR**_____

Student's Name:	Grade:	Student's Weight:
Birthdate:	Allergic to:	Asthma: ☐ Yes ☐ No

EMERGENCY TREATMENT / MILD Symptoms

If student experiences a few hives; itchy skin; swelling at site of insect sting OR
if an ingestion (or sting) is ***suspected*** watch for progression to SEVERE symptoms.

Treatment:

- Send student to health clinic ACCOMPANIED BY AN ADULT
- Give _____ of _____ by mouth if ordered.
  Amount Antihistamine
- Contact the PARENT or emergency contact person.
- Student should rest. MONITOR closely for improvement or worsening of symptoms until parent arrives. Prepare to give Epinephrine if needed.

EMERGENCY TREATMENT / SEVERE Allergic Reaction – CALL 911

SYMPTOMS: Mild symptoms may become SEVERE. Signs of a life threatening reaction may include:

MOUTH	**itching swelling of lips and/or tongue, metallic taste in mouth**
THROAT	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling (more than a localized reaction)**
GUT	**nausea, vomiting, diarrhea, cramps**
LUNG	**shortness of breath, cough, wheeze, trouble swallowing, nasal congestion/sneezing**
HEART	**weak pulse, dizziness, passing out, low blood pressure**
BEHAVIOR	**anxiety, difficulty talking/slurred speech, headache, confusion, "feeling of doom"**

TREATMENT: ****911 should always be called when an EPINEPHRINE AUTO-INJECTOR is given**

- **Give EpiPen® Auto-Injector immediately** for severe symptoms or more than one mild symptom
- **Call 911** (or local emergency response team) immediately. **EpiPen® only lasts 20-30 minutes**
- **Contact parents or emergency contact person**
- **When parents are unavailable, school personnel should accompany the child to the hospital**

Directions for use of EpiPen®:	**Directions for use of Auvi-Q®**
• *Remove from case - Pull off BLUE safety cap* • *Place ORANGE tip against upper outer thigh* • *Press hard into outer thigh, until it clicks* • *HOLD in place 10 seconds, then remove* • *Discard EpiPen® in "sharps container" or give to the emergency medical responder* *(Do not return to holder)*	• *Pull device out from case* • *Follow VOICE PROMPTS for directions* • *Press hard into outer thigh, until it clicks* • *HOLD in place 5 seconds, then remove* • *Discard Auvi-Q® in "sharps container", or give to the emergency medical responder* *(Do not return to holder)*

PHYSICIAN INSTRUCTIONS:

YES NO Student understands proper use and may carry their EpiPen®.

YES NO Epinephrine Auto-Injector in clinic (0.15 MG____0.3 MG____) – *must be provided by parent*

YES NO Antihistamine (Benadryl) in clinic - *must be provided by parent*

Additional Instructions: _____

PHYSICIAN NAME:		**SIGNATURE**:
Phone Number:	Fax Number :	Date:

PARENT: I give consent with my signature for this information to be shared with Staff and the Healthcare provider.

PARENT/GUARDIAN NAME:	**SIGNATURE**:
Phone Number(s):	Date:

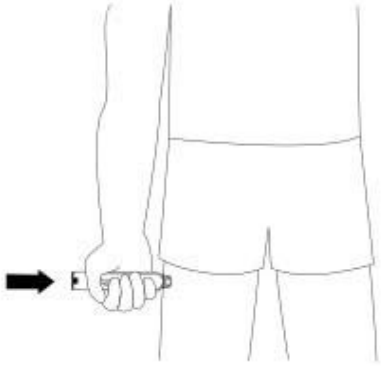
☐ *Copy provided to Parent* ☐ *Copy sent to Healthcare Provider*

APPROVED: 10/6/15

EpiPen® (epinephrine) Auto-Injector Directions

- **First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

- **Hold orange tip near outer thigh (always apply to thigh)**



- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.**

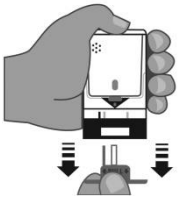
Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

EPIPEN 2-PAK® EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Mylan Specialty L.P.

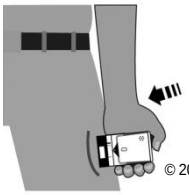
Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.



Pull off RED safety guard.

Place black end against outer thigh, then press firmly and hold for 5 seconds.



Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

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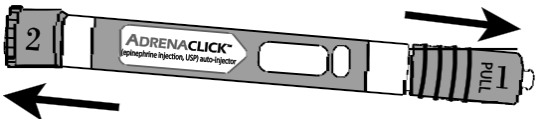
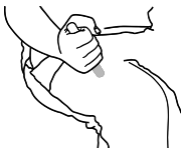
Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions





Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

EXHIBIT E

Northwest Independent School District

Self-Administration of Asthma Medicine

Student Name:	**Campus:**	**Date:**

A student with asthma may possess and self-administer prescription asthma medicine while on school property or at a school-related event or activity if:

1. The medicine has been prescribed for that student as indicated by the prescription label on the medicine.
2. The self-administration is done in compliance with the prescription or written instructions from the student's physician or other licensed health care provider.
3. A parent of the student provides to the school:
    a. Written authorization, **signed by the parent**, for the student to self-administer the medicine while on school property or at a school-related event or activity; AND
    b. Written statement, **signed by the student's physician** or other licensed health care provider that states:

This student, _____, has asthma and is capable of self-administering the following inhaler: _____.
(include full prescribing information)
The purpose of this medicine is: _____.
I have discussed appropriate safety measures with the student and family members.

Physician Name: (Print)	**Physician Signature:**
Office Phone Number:	Office Fax Number:

Parent/Guardian

I request that my student be allowed to self-administer the above asthma inhaler.

Parent/Guardian Name: (Print)	**Parent/Guardian Signature:**
Home Phone Number:	Cell Phone Number:

APPROVED: 10/6/15

EXHIBIT F

Northwest Independent School District

Severe Food Allergy
Student Permission for Placement at Designated Table/Area

Print Student's Last Name	*First Name*	*MI*
Teacher	*Grade*	
Please list Severe Food Allergy	*Date*	

As the parent/guardian of the above-named student, my signature hereby grants permission for him/her to have lunch, snacks and/or other activities where food is served at a table or area specifically designated for students of like severe food allergies. I understand that this attempt to protect the above-named student from ingesting and/or from contact with food or food particles of which the above-named student is allergic, is executed as a precautionary measure that is in the best interest of my child, and releases the school and district from any violations of confidentiality and the Family Education Rights of Privacy Act (FERPA).

It is understood that neither Northwest Independent School District, nor any of its trustees, officers, employees, or organization sponsors are liable for any accidental ingestion or accidental contact with the above-stated food of which the above-named student is allergic. I acknowledge that in case of an emergency, illness, or accident an attempt will be made to reach the emergency contact people I have listed below. However, if no one can be reached, I authorize the school officials to take whatever action is deemed necessary in their judgment, for the health of my child. I will be responsible for any and all costs in the event my child must be transported by ambulance.

**Please note my child has the following allergies/medical conditions and/or is currently taking the following medications.

Emergency Contact	*Relationship*	*Primary Phone*	*Work Phone*

Printed Parent/Guardian Name	
Parent/Guardian Signature	*Date*

APPROVED: 10/6/15