CARROLL COUNTY PUBLIC SCHOOLS MEDICATION FORM

This page to be completed by school nurse

Student Name:_____ **D.O.B**_____ **School:**_____

Auto-injector Epinephrine Expiration Date:_____ **Antihistamine Expiration Date:**_____

If medication administration is necessary during school hours, this form must be completed before any representative of the school can administer prescription or non-prescription medications to your child. **Special Notes:**

1. **Prescription Medications must be in a container marked specifically for student, labeled by pharmacist or prescriber. Over the counter medications must be in original container with manufacturers label intact.**
2. **All homeopathic/herbal prescription AND non-prescription medicines require a parent AND authorized prescriber signature. In Maryland an authorized prescriber is a physician, nurse practitioner, certified midwife, podiatrist, and physician assistant or dentist.**
3. **Medications are not to be transported by students. This is in violation of our Drug-Alcohol policy. Medication shall be returned to the parent/ responsible adult when the order or the medication has expired. Nurse should notify parent/guardian of medication which expires during the school year. Expired medication not collected by parent/guardian or designated responsible adult will be discarded within 7 calendar days. All medications not claimed at the end of the school year will be destroyed.**
4. **Medication orders are only valid for the current school year including ESY.**

*** (Maryland law allows prescription medication to be used only for 1 year beyond date of issue or expiration date indicated on the medication – whichever comes first.)**

Codes (chart reason)

A – Absent
C – School Closed
E – Early Dismissal
F – Field Trip
H – Holiday
L – Late Opening
N – None Available
O – No Show
W – Dose Withheld

Initial	Name	Initial	Name
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
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January																															
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March																															
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May																															
June																															
July																															

Notes:_____

CARROLL COUNTY PUBLIC SCHOOLS
ALLERGIC REACTION EMERGENCY PLAN & MEDICATION ORDERS

SCHOOL YEAR: _____

NAME: _____ D.O.B: _____ GRADE/TEACHER: _____ BUS # _____

STUDENT HAS A SEVERE ALLERGY TO: _____

ASTHMATIC: □Yes* □ No (*High Risk for Reaction) Other Allergies: _____

History of Anaphylaxis: □Yes □ No Date of Last Reaction: _____ Date of Last Hospitalization: _____

Anaphylaxis (Severe allergic reaction) is an excessive reaction by the body to combat a foreign substance that has been eaten, injected, inhaled or absorbed through the skin. It is an intense and life-threatening medical emergency. **Do not hesitate to give Epi auto-injector and call 911.**

USUAL SYMPTOMS of an allergic reaction:

MOUTH-Itching, tingling, or swelling of the lips, tongue or mouth
THROAT-Sense of tightness in the throat, hoarseness and hacking cough
LUNG-Shortness of breath, repetitive coughing, and/or wheezing
GENERAL- Panic, sudden fatigue, chills, fear of impending doom
SKIN-Hives, itchy rash, and/or swelling about the face or extremities
GUT-Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea
HEART-"Thready" pulse, "passing out", fainting, blueness, pale

This Section to be Completed by a Licensed Healthcare Provider (LHP)

- Is the student's allergy considered Life-Threatening: □ Yes □ No
- Is the reaction related to:
  □ Skin Contact □ Inhalation □ Ingestion
  □ Other: (explain) _____
- What was the student's reaction when exposed? _____
- Can the student be in the same room with the allergen?
  In a small class/restricted space? □ Yes □ No In a large space (cafeteria, gymnasium)? □ Yes □ No
- **IF STUDENT HAS PEANUT ALLERGY, STUDENT WILL SIT AT PEANUT FREE TABLE? □ Yes □ No**

MEDICATION ORDERS (Medication orders will only be good for current school year/summer session/ESY)

If a student has symptoms or is exposed to the allergen (is stung, eats food he/she is allergic to, or exposed to something allergic to):

- **Give antihistamine: Prior to onset of symptoms □ After Epinephrine Auto-Injector is given □ Other** _____
  Drug: _____ Strength: _____ Dose: _____ Route: _____
  Give Epi auto-injector □ 0.3 mg □ Jr. 0.15 mg (If administered call 911)
  □ May repeat Epi auto-injector (if available) in _____ minutes if symptoms are not relieved or symptoms return and EMS has not arrived.
  Student is able to self-administer □ yes □ no **Student may carry auto-injector on self** □ yes □ no
  Parent/Guardian must supply a back-up auto-injector to be kept in the health suite.
- **Place student in a side lying recovery position or reclining position with legs elevated (if comfortable breathing) until EMS arrives.**
- Supply to EMS time Epi was administered. Give used auto-injector to EMS personnel.
- Notify school administration and parents.

Special Instructions: _____

_____

_____ _____ _____
Health Care Provider Name (Print) Health Care Provider Signature / Date Phone/Fax

_____ _____
Parent Signature / Date Reviewed by School Nurse / Date