Delphos City Schools

MEDICATION INFORMATION FORM
FOR THE ADMINISTRATION AND/OR SELF-POSSESSION OF EPINEPHRINE AUTOINJECTORS

Many students are receiving medication under a doctor's supervision. It is important that the school be aware of the effects the medication might have or is having on the school performance of the students. School personnel are occasionally requested to administer the medication. Under these circumstances, it is necessary that specific physician's recommendations be made available to the school.

NAME OF STUDENT: _____ BLDG. _____ GRADE: _____

STUDENT ADDRESS: _____ TEACHER : _____

NAME OF AUTOINJECTOR MEDICATION: _____

RECOMMENDED DOSAGE/ROUTE: _____

MEDICATION TO START: _____ END DATE: (if known) _____

TIMES ADMINISTERED: _____

OTHER MEDICATIONS STUDENT IS TAKING: _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OR STORAGE OF MEDICATION: _____

_____

REACTIONS: The physician/pharmacologist is urged to list potential reactions the student might have to the medication:

_____

IN THE EVENT THE STUDENT IS UNABLE TO ADMINISTER THE ANAPHYLAXIS MEDICATION OR THE MEDICATION DOES NOT PRODUCE THE EXPECTED RELIEF FROM THE STUDENT'S ANAPHYLAXIS, SCHOOL EMPLOYEES SHOULD FOLLOW THE FOLLOWING PROCEDURES:_____ _____

_____

LIST ANY SEVERE REACTIONS THAT MAY OCCUR TO THE CHILD USING THE AUTOINJECTOR THAT SHOULD BE REPORTED TO THE PHYSICIAN: _____

ANY SEVERE REACTIONS THAT MAY OCCUR TO ANOTHER CHILD, FOR WHOM THE AUTOINJECTOR IS NOT PRESCRIBED, SHOULD SUCH A CHILD RECEIVE A DOSE OF THE MEDICINE:

_____

OTHER SPECIAL INSTRUCTIONS FROM PHYSICIAN: _____

The parent agrees to provide a back-up dose of the anaphylaxis medication to the school principal, or if a school nurse is assigned to the student's building, the school nurse. During school hours, it is my understanding that the school secretary, principal, school nurse AND/OR the above stated child will administer the prescribed medication according to the specified physician's recommendation. The school nurse may contact this physician at any time for information about my child's condition. This form is valid for current school year only and will serve as a Medical Release Form between school and healthcare provider.

The above stated child has been instructed on proper use, storage, and administration of the prescribed auto-injector and has demonstrated competency in self administration. ☐ Yes ☐ No

(Parent and Physician signatures required below)

Parent Signature: _____ **Phone:** _____ **Date:** _____

Physician Signature: _____ **Phone:** _____ **Date:** _____

ALLERGY CARE PLAN

STUDENT NAME: _____

You have indicated that the above named student has a **SEVERE** or **SERIOUS ALLERGY**. It is important to have at least annual health information when she/he needs help at school. Please complete this form and return it to school tomorrow so a plan can be established and shared with appropriate school personnel. It is the responsibility of the parent/guardian to provide necessary special food and medicine needed at school. If you have any questions, please call the school. **REMEMBER TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN PHONE NUMBERS, CONTACT PERSONS, ETC.**

Check any life-threatening allergy this student has:

☐ Insect stings – list type _____ ☐ Food – list type _____

☐ Animals – list type _____ ☐ Other – list type _____

Indicate the signs that are usually present during an allergy attack

☐ Difficulty breathing ☐ Very pale skin ☐ Swelling – Where? _____

☐ Rash ☐ Loss of consciousness

☐ Nausea ☐Difficulty swallowing How much? _____

☐ Flushed Skin ☐ Other _____

Has emergency medical treatment been needed in the past year for allergies? ☐ No ☐ Yes When? _____

Allergies currently being treated by: _____ Phone: _____

Are medications needed to control or treat the allergies? List below the medications needed.

Medication	Amount taken	Time of day	Taken at school[1]

The usual treatment at school for a severe allergic reaction is to:

1. **Observe for inadequate breathing, signs of shock, unusual swelling.**
2. **When observed, call 911**
3. **Report to parent**

Please indicate any additional information that you want to share[2]

_____

_____

_____

Parent Signature: _____ **Date:** _____

[1]The district medication policy requires parental and physician signatures on district forms for all medications administered during school activities.

[2]Any treatments or test and activities restrictions require written directions from the student's physician or primary care provider.