

Administration of Medication Form

FORT THOMAS INDEPENDENT SCHOOL DISTRICT

Robert D. Johnson Elementary
441-2444 fax: 572-4948

Samuel Woodfill Elementary
441-0506 fax: 441-2755

Highlands Middle School
441-5222 fax: 441-4210

Ruth Moyer Elementary
441-1180 fax: 441-9440

Highlands High School
781-5900 fax: 442-4212

Dear Parent or Guardian:

If your child requires medication, if possible, please try to schedule it before or after school hours. If the medication is to be given during school hours, we must have this form completed and signed by you and your child's physician. Your doctor may fax this form to the school office. The duration of this form is for one (1) school year only.

SCHOOL YEAR _____

Name: _____ Date of Birth _____
Grade: _____ Allergies: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER		
Medication: _____	Dosage: _____	Directions: _____
Administration Time: Lunch _____ or _____	Route: _____	Diagnosis: _____
Possible side effects: _____	Duration: Start: _____	Stop: _____
Medication: _____	Dosage: _____	Directions: _____
Administration Time: Lunch _____ or _____	Route: _____	Diagnosis: _____
Possible side effects: _____	Duration: Start: _____	Stop: _____
Medication: _____	Dosage: _____	Directions: _____
Administration Time: Lunch _____ or _____	Route: _____	Diagnosis: _____
Possible side effects: _____	Duration: Start: _____	Stop: _____

<p>****For inhaler, Epipen, FDA approved seizure rescue medication, and/or Glucagon, the student has received training to carry the inhaler or emergency medication and may carry and self-administer this medication.</p> <p align="right"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>****For field trips, the student has received training and may carry and self-administer the medication/s listed above.</p> <p align="right"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

I give permission for the administration of this medication/s by trained school personnel according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication/s. School officials may need to contact the ordering physician if additional information is needed. I hereby authorize release of any needed information from the ordering physician regarding this medication. Student may self-administer the above medication/s with school trained personnel supervision while on a field trip. In the case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary.

Parent/Guardian Signature	Parent's Phone	Date
Physician's Signature	Physician's Phone	Date
Print Physician's Name	Physician's Address	Fax Number

For student health services/procedures not involving medication only, please refer to 09.22 AP.22.
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REVIEW/REVISED:7/11/2016

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: **Yes (higher risk for a severe reaction)** **No**

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

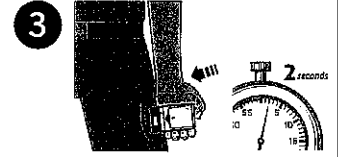
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____



HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



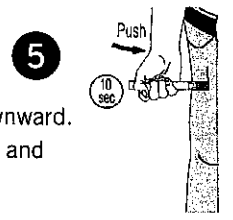
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



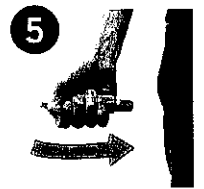
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

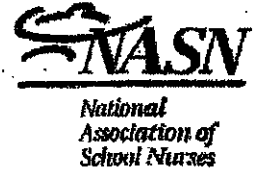
PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____



Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
 Parent/Guardian: _____ Today's Date: _____
 Home Phone: _____ Work: _____ Cell: _____
 Primary Healthcare Provider: _____ Phone: _____
 Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: No Yes

2. History and Current Status

<p>a. What is your child allergic to?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Peanuts</td> <td><input type="checkbox"/> Insect Stings</td> </tr> <tr> <td><input type="checkbox"/> Eggs</td> <td><input type="checkbox"/> Fish/Shellfish</td> </tr> <tr> <td><input type="checkbox"/> Milk</td> <td><input type="checkbox"/> Chemicals _____</td> </tr> <tr> <td><input type="checkbox"/> Latex</td> <td><input type="checkbox"/> Vapors _____</td> </tr> <tr> <td><input type="checkbox"/> Soy</td> <td><input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish/Shellfish	<input type="checkbox"/> Milk	<input type="checkbox"/> Chemicals _____	<input type="checkbox"/> Latex	<input type="checkbox"/> Vapors _____	<input type="checkbox"/> Soy	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)	<input type="checkbox"/> Other: _____		<p>b. Age of student when allergy first discovered: _____</p> <p>c. How many times has student had a reaction? <input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> More than once, explain: _____</p> <p>d. Explain their past reaction(s): _____</p> <p>e. Symptoms: _____</p> <p>f. Are the food allergy reactions: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse</p>
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings												
<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish/Shellfish												
<input type="checkbox"/> Milk	<input type="checkbox"/> Chemicals _____												
<input type="checkbox"/> Latex	<input type="checkbox"/> Vapors _____												
<input type="checkbox"/> Soy	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)												
<input type="checkbox"/> Other: _____													

3. Trigger and Symptoms

- a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____
- b. How does your child communicate his/her symptoms? _____
- c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days
- d. Please check the symptoms that your child has experienced in the past:
- | | | | | | |
|-------------------|--|---|---|-----------------------------------|---|
| Skin: | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Flushing | <input type="checkbox"/> Swelling (face, arms, hands, legs) |
| Mouth: | <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling (lips, tongue, mouth) | | | |
| Abdominal: | <input type="checkbox"/> Nausea | <input type="checkbox"/> Cramps | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | |
| Throat: | <input type="checkbox"/> Itching | <input type="checkbox"/> Tightness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Cough | |
| Lungs: | <input type="checkbox"/> Shortness of breath | | <input type="checkbox"/> Repetitive Cough | | <input type="checkbox"/> Wheezing |
| Heart: | <input type="checkbox"/> Weak pulse | <input type="checkbox"/> Loss of consciousness | | | |

4. Treatment

<p>a. How have past reactions been treated? _____</p> <p>b. How effective was the student's response to treatment? _____</p> <p>c. Was there an emergency room visit? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>d. Was the student admitted to the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____</p> <p>f. Has your healthcare provider provided you with a prescription for medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>g. Have you used the treatment or medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>h. Please describe any side effects or problems your child had in using the suggested treatment: _____</p>
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5. Self Care.

a. Is your student able to monitor and prevent their own exposures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Does your student:		
1. Know what foods to avoid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Ask about food ingredients	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Read and understands food labels	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Tell an adult immediately after an exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Wear a medical alert bracelet, necklace, watchband	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Tell peers and adults about the allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Firmly refuses a problem food	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Does your child know how to use emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Has your child ever administered their own emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy?	_____
b. Does your child carry epinephrine in the event of a reaction?	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Has your child ever needed to administer that epinephrine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. Do you feel that your child needs assistance in coping with his/her food allergy?	_____

7. General Health

a. How is your child's general health other than having a food allergy?	_____
b. Does your child have other health conditions?	_____
c. Hospitalizations?	_____
d. Does your child have a history of asthma?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, does he/she have an Asthma Action Plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Please add anything else you would like the school to know about your child's health:	_____ _____

8. Notes:

Parent / Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

FORT THOMAS INDEPENDENT SCHOOLS
EMERGENCY MEDICATION ADMINISTRATION
DURING EXTRACURRICULAR ACTIVITIES

Student Name: _____

Grade: _____

Date: _____

Please list any sports/extracurricular activities that your child will be participating in during the school year: _____

I, _____, parent of _____, am aware that my child may require the administration of _____ in an emergency situation that occurs before or after normal school hours. I agree to inform the school nurse that my child will participate in extracurricular activities and to inform the coach, leader or responsible adult for these extracurricular activities of my child's condition. **I will supply additional necessary emergency medications or supplies to coaches/leaders for use during these activities.** The school nurse will make available the necessary training to coaches/leader in the administration of these medications. If emergency medication administration is required, 911 will also be called.

If I do not make the medications available, I understand and agree that only 911 will be called in the event of an emergency.

If my child adds additional activities during the school year, I agree to notify the school nurse and coaches/leaders or responsible adult for these extracurricular activities of my child's condition.

(Signature of parent/guardian)

(Date)