See the following pages regarding administering medication and emergency health care to students:

Exhibit A: Request for Administration of Medication — 2 pages

Exhibit B: Request for Athletic Trainer to Administer Medication — 2 pages

Exhibit C: Guidelines for Physical Examination of a Student — 1 page

Exhibit D: Physician's Statement for Student Held Inhaler — 1 page

Exhibit E: Parent's Statement for Student Use of Mosquito Repellent — 1 page

Exhibit F: Autorización de los Padres Para el Uso de Repelente de Mosquitos por el Estudiante — 1 page

Exhibit G: Physician's Statement for Student Held Epi-Pen — 1 page

Exhibit H: Physician's Statement for Administration of Special Health Care Services — 2 pages

Exhibit I: Food Allergy Action Plan — 2 pages

Exhibit J: Child Nutrition Services Information Card — 1 page

EXHIBIT A

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
REQUEST FOR ADMINISTRATION OF MEDICATION

This form must accompany each medication to be administered, whether prescription or nonprescription. Additional copies of this form are available in the nurse's office or copies may be made of this sheet.

To: Principal, _____ (school name)

Date: _____

As parent/guardian of _____, a student in the _____ grade, I (print parent's name) _____, give permission for the Spring Branch Independent School District to administer to my child, the following medication:

Name of medication: _____

Color: _____ Dose (amount) to be administered: _____

Time to be administered: _____

Date to discontinue: _____

Additional instructions or side effects regarding the above medication:

_____

Reason for administering medication: _____

Student's physician name: _____

Telephone number: (____) _____

Prescription medication must be in the original container with the student's name, the doctor's name, and a current date. It will be given according to the instructions on the label. The label and the order must match. Each prescription medication must have a new order from the doctor each time there is a dosage change or an interruption in administration, such as with antibiotics.

Nonprescription medication must be in the original container and will be given according to directions.

Medication for students in elementary schools must be brought to the school by the parent.

Medication may not be transported by elementary students on the bus.

School clinic staff is authorized to contact and consult with your child's physician regarding the child's medical needs.

The District, the Board, and the staff will be immune from civil liability for damages or injuries resulting from the administration of medication to a student.

Parent/Guardian Signature: _____

Work Phone: (_____)_____ Home Phone: (_____)_____

Physician's Signature (if required*): _____

Date: _____

* Required annually in treatment of long-term medication administration as in asthma, diabetes, chronic infections, Attention Deficit Disorder, controlled medicines, and over-the-counter medicines given daily for more than two weeks.

EXHIBIT B

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
REQUEST FOR ATHLETIC TRAINER TO ADMINISTER MEDICATION

To: Principal, _____ (school name)

Date: _____

I, _____ (name), am the parent/guardian of

_____ (student's name), a student in the _____ grade.

I request that an athletic trainer employed by the Spring Branch Independent School District give my child the following medication(s) as needed:

NONPRESCRIPTION MEDICATIONS

Check the nonprescription medication(s) below that you request to be administered to your child by the athletic trainer on an "as needed" basis:

	Tylenol		Aleve
	Advil		Pepto-Bismol
	Advil Cold and Sinus		Robitussin Cough Formula
	Cepacol Throat Lozenges		Hydrocortizone Cream
	Chloraseptic Spray		Triple Antibiotic Ointment
	Oral Gel		Other (Specify, i.e., Blistex, etc.)
	Antacid		

PRESCRIPTION MEDICATION

I request that the following, _____ (name of

prescription medicine), be administered to my child, _____,

when prescribed by a physician.

Prescription medication must be in the original container with the student's name, the doctor's name, and a current date. It will be given according to the instructions on the label. The label and the order must match. Each prescription medication must have a new order from the doctor each time there is a dosage change or an interruption in administration, such as with antibiotics.

Name of prescription medication: _____

Color: _____ Dose (amount) to be administered: _____

Time(s) to be administered: _____

Additional instruction or side effects regarding any of the above medication(s):

_____

Student's Personal Physician's Name: _____

Telephone Number: _____

The District, the Board, and the staff will be immune from civil liability for damages or injuries resulting from the administration of medication to a student.

I give permission for my child, _____ (Student's Name), to receive medication as instructed on this form.

Parent/Guardian Signature: _____

Work Phone: (_____)_____ Home Phone: (_____)_____

Date: _____

EXHIBIT C

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
GUIDELINES FOR PHYSICAL EXAMINATION OF STUDENT

The guidelines are:

1. Nurses, nurse assistants, and other appropriate school personnel may perform only those physical examinations necessary to respond to immediate health needs.
2. A nurse, nurse assistant, or other appropriate school personnel may determine that it is necessary to roll up a shirt sleeve or pant leg, remove a jacket or shirt, or loosen or remove pants in order to adequately examine the student.
3. Except as otherwise provided in this guideline, undergarments may be removed from a student only if a nurse, nurse assistant, or other school personnel determines a medical necessity exists, including suspected abuse. When such a determination is made, undergarments may be removed from a student only if another adult of the same gender as the student is present.
4. In an emergency situation, school personnel may remove a student's undergarments without the presence of another adult of the same gender as the student if immediate action regarding the student's health is required.
5. School personnel may remove a student's undergarments without the presence of another adult of the same gender if the school personnel is changing diapers, assisting with toileting, or cleaning a child after a toileting accident.

EXHIBIT D

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
PHYSICIAN'S STATEMENT FOR STUDENT HELD INHALER

Student's Name _____ Birth date _____

School _____ Grade _____

It is necessary that the following medication be administered during school hours as specified in order to maintain this child's physical health and support school performance. I agree to the terms of the contract listed below:

NAME OF MEDICATION _____ DOSAGE _____

TIME _____ FREQUENCY OF USE _____

Condition for which medication is prescribed _____

Medication may cause _____

Emergency Instructions _____

_____ _____
Physician's Name (Please Print) Physician's Signature (Original)

_____ _____
Date Telephone Date

Contract for Special Use—Inhaler

The student listed above may carry his/her inhaler according to the physician/parent statements if he/she is in compliance with the conditions listed below:

- The student has demonstrated to the nurse/nurse assistant the correct use of the inhaler.
- The student agrees to never share the inhaler with another person.
- The student agrees that after taking the initial dose prescribed, and if there is not marked improvement, he/she will go immediately to the health room.
- The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review status.

_____ _____
Signature of Student Date

I hereby grant permission for my child to carry the inhaler described above. I understand that he/she must follow the rules listed and I will notify the school of changes in my child's medication and/or condition. If necessary, I also grant permission for the school nurse or other school personnel to administer medication to my child according to the physician's statement above.

_____ _____
Signature of Parent/Guardian Date

Medication must be prescribed by a licensed physician and appropriately labeled in the original container by the pharmacy or physician.

EXHIBIT E

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
PARENT'S STATEMENT FOR STUDENT USE OF MOSQUITO REPELLENT

Student's Name _____ Birth date _____

School _____ Grade _____

I am requesting that my child be allowed to apply mosquito repellent during school hours as specified below in order to maintain my child's physical health.

Name of Repellent _____

Frequency of Use _____

☐ Lotion ☐ Wipes ☐ Other

Additional information related to this request _____

_____

If there is evidence of a reaction to this medication, please contact me according to the information below or as indicated on my child's emergency procedure card on file at school.

_____

I hereby grant permission for my child to apply mosquito repellent according to the statement given above.

_____ _____
Parent/Guardian Name (Please Print) Signature of Parent/Guardian

_____ _____ _____
Address Telephone Date

Important Information for Parents/Guardians: The repellent listed above must be supplied by the parent/guardian and must be in the original manufacturer's container with an original label containing dosage instructions.

EXHIBIT F

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
SERVICIOS DE SALUD AUTORIZACIÓN DE LOS PADRES
PARA EL USO DE REPELENTE DE MOSQUITOS POR EL ESTUDIANTE

Nombre del Estudiante _____ Fecha de Nacimiento _____

Escuela _____ Grado _____

Estoy solicitando que mi niño(a) sea permitido usar repelente de mosquitos durante las horas de escuela, de acuerdo con las especificaciones posteriores en orden de mantener la salud física de mi niño(a).

Nombre de Repelente _____

Frequencia de uso _____

☐ Loción ☐ Toallitas ☐ Otros

Información adicional relacionada a esta solicitud _____

_____

Si hay evidencia de una reacción a esta repelente, por favor comuníquese conmigo de acuerdo con la información siguiente o con lo indicado en la targeta de emergencia archivada en la escuela.

Doy mi permiso para mi niño(a) uso repelente de mosquitos de acuerdo con los especificado anteriormente.

_____ _____
Padre/Guardian (Por favor use letra de imprenta) Firma del Padre/Guardian

_____ _____ _____
Dirección Teléfono Fecha

Información Importante para los Padres/Guardianes: La repelente listada anteriormente debe ser proporcionada po el padre/guardian y debe ewtar en el frasco original de manufactura con las instrucciones de dosificación en la etiqueta original.

EXHIBIT G

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
PHYSICIAN'S STATEMENT FOR STUDENT HELD EPI-PEN

Student's Name _____ Birth date _____

School _____ Grade _____

It is necessary that the following medication be administered during school hours as specified in order to maintain this child's physical health and support school performance. I agree to the terms of the contract listed below:

NAME OF MEDICATION _____ DOSAGE _____

TIME _____ FREQUENCY OF USE _____

Condition for which medication is prescribed _____

Medication may cause _____

Emergency Instructions _____

_____ _____
Physician's Name (Please Print) Physician's Signature (Original)

_____ _____
Date Telephone Date

Contract for Special Use — Epi-pen

The student listed above may carry his/her epi-pen according to the physician/parent statements if he/she is in compliance with the conditions listed below:

- The student has demonstrated to the nurse/nurse assistant the correct use of the epi-pen.
- The student agrees to never share the epi-pen with another person.
- The student agrees that after taking the initial dose prescribed he/she will go immediately to the health room or have the nurse called to his/her location. EMS will be activated as necessary.
- The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review status.

_____ _____
Signature of Student Date

I hereby grant permission for my child to carry the epi-pen described above. I understand that he/she must follow the rules listed and I will notify the school of changes in my child's medication and/or condition. If necessary, I also grant permission for the school nurse or other school personnel to administer medication to my child according to the physician's statement above.

_____ _____
Signature of Parent/Guardian Date

Medication must be prescribed by a licensed physician and appropriately labeled in the original container by the pharmacy or physician.

EXHIBIT H

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
ELIGIBILITY REPORT PHYSICIAN'S STATEMENT
FOR ADMINISTRATION OF SPECIAL HEALTH CARE SERVICES

Student's Name _____ Grade _____ Age _____ Birth date _____

Parent/Guardian _____ School _____

*It is necessary that special health care services be administered during school hours in order to maintain this child's physical health, support school performance and/or meet transportation requirements.

Health Service prescribed _____

Condition for which service is prescribed _____

Frequency Duration _____

Method of Administration _____

Equipment Needed _____

Equipment Care Method _____

Special Instructions _____

Possible Reactions _____

(Please contact child's parent/guardian or my office)

To the physician: Please initial the appropriate box below:

☐ I have reviewed/approved the attached standardized procedure as written.
☐ I have reviewed/approved the attached standardized procedure with written modifications.
☐ I have attached my alternate/additional procedure and/or recommendations.

To the physician: Indicate unlicensed personnel who may perform this service with indirect supervision.

☐ Nurse assistant ☐ Teacher ☐ Classroom Assistant

☐ Office Staff ☐ Transportation Assistant

I certify that this student is under my continuing care, which includes monitoring his/her continuing need for the services and any needed modifications of the services prescribed above.

_____ _____
Licensed Physician's Name (Please Print) Licensed Physician's Signature (Original)

_____ _____ _____
Address Telephone Date

I hereby grant permission for the school nurse and/or other school personnel so designated to administer this health service to my child according to the physician's statement given above.

Signature of Parent/Guardian Date

* Denoted items required by Special Education

EXHIBIT I

SBISD Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
☐ If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
☐ Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
☐ Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
☐ Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
☐ Throat† Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
☐ Lung† Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
☐ Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
☐ Other† _____	☐ Epinephrine ☐ Antihistamine
☐ If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

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

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

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

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent_____ Phone Number(s):_____
4. Emergency Contacts
   a. Name/Relationship:_____ Phone Number(s):_____
   b. Name/Relationship:_____ Phone Number(s):_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____Date_____

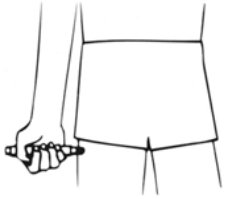
Doctor's Signature (Required)_____Date_____

TRAINED STAFF MEMBERS

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**
- 

- **Hold black tip near outer thigh (always apply to thigh).**
- 
- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**
- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**
- **Slide yellow collar off plunger.**
- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods

EXHIBIT J

SBISD Child Nutrition Services Information Card

Parents shall submit a *Child Nutrition Services* Information Card
at the beginning of each school year.

By law, any food allergies requiring menu substitutions must be signed by a Licensed Physician.

Student's Name:	School:
Special Diet or Dietary Restrictions:	
Food Allergies or Intolerances:	
Food Substitutions:	
Foods Requiring Texture Modifications: Chopped: Finely Ground: Pureed or Blended:	
Other Diet Modifications:	
Feeding Techniques:	
Supplemental Feedings:	
Physician or Medical Authority: Name: Telephone: Fax:	
Additional Contact Name: Telephone: Fax:	Additional Contact Name: Telephone: Fax:
Person Completing Form:	Date:

***Submit a copy of this form to the *Child Nutrition Services* Department.**