AMSA
ADVANCED MATH & SCIENCE ACADEMY
INTEGRITY · EXCELLENCE · COMMUNITY

201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE
Phone 508 597-2475/2473 Medical FAX 508 597-0825

IMPORTANT PLEASE READ

Dear Parents/Guardians

If medication(s) is required for administration for next school year (08-24 to 06-25) please remember to follow these important steps:

- Download the appropriate forms from our website. Parents will be able to download the forms from our website, https://www.amsacs.org , 2024. (Click Parents-Health Office-Medical Forms)
- Orders must be written, and are only active for the current school year.**(Need to be dated after 07-01-24)**
- **Physicians have their own office forms for medication orders and actions plans (allergy/asthma/diabetic/seizure action). It is the parents responsibility to request these forms from your child's physician. Please remeber we cannot administer medications without those forms.**
- **Physicians must provide medication orders that include the name of the medication, form of medication (tablet/capsule/ liquid/injection), frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.**
- **Physicians must provide any action plans. If your child is having medication ordered for allergies/asthma/ diabetes/seizures, then the Physician must supply an Action plan for that specific medication.**
- **PLEASE NOTE IF A NURSE IS NOT ON A FIELD TRIP BENADRYL CAN NOT BE GIVEN-ASK YOUR MEDICAL PROVIDER TO MAKE NOTE OF THIS- EPIPEN WILL BE USED AND 911 CALLLED.**
- No order can be accepted that is dated before 07-01-24. Please have the physician date the orders accordingly.
- Remember **only one medication per order form** Please copy or print additional forms from the website if more forms are needed.
- Please review the AMSACS medication administration policy.
- Bring medications to school before the first day of school in the original container. You may call the health office **after 08-19-2024** to arrange drop off. No student is allowed to carry any medications to school, even over-the-counter medications.
- We have included a check list (on the back of this form) for your convenience. **Please print double sided**.

Thank you and have a healthy, happy safe summer ☺

PARENT EPINEPHRINE MEDICATION CHECK LISTS

Checklist for Required Paperwork for **Epinephrine Orders**

PHYSICIAN TO PROVIDE

1. _____ Physician's Order Form
2. _____ Allergy Action Plans (If your child's MD does not have an action plan he/she must send a note stating they do not have action plan one and why.

Parent to Complete:

1. _____ Parent's Permission for Epinephrine Administration
2. _____ Epinephrine Contract to carry if applicable
3. _____ Allergy History

If you need this information translated, please copy and paste it into Google Translate. The link to Google Translate is http://translate.google.com/

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Si necesita que se le traduzca esta información, por favor, copie y pegue en Google Translate. El enlace de Google Translate es http://translate.google.com/

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Rúguǒ nín xūyào fānyì cǐ xìnxī, qǐng jiāng qí fùzhì bìng zhāntiē dào Google fānyì zhōng. Gǔgē fānyì de liànjiē shì http://Translate.Google.Com/

Arabic إذا كنت بحاجة إلى ترجمة هذه المعلومات فالرجاء نسخها ولصقها في ترجمة Google. الرابط إلى ترجمة Google هو :http://translate.google.com/

PARENT/GUARDIAN CONSENT FOR PRESCRIPTION
EPINEPHERINE AUTO-INJECTOR MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

My son/daughter is currently receiving the following medications: (please list all medications the child is receiving, including those given during the school day.)

1. _____ 2. _____ 3. _____4. _____

My son/daughter has the following food or drug allergies and may require the use of epinephrine according to my child's physician: _____

I consent to have the school nurse or his/her delegate administer the medication ***Epinephrine Auto Injector*** as prescribed by my child's physician.

1. I give permission to allow the administration of epinephrine by auto-injection to my child by the school nurse or in the absence of the school nurse, by an unlicensed school member who has been Epinephrine Auto-injector trained, in the event of an emergency. I also allow the school nurse to share with appropriate school personnel information relative to this medication administration plan.
2. I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate (check one) _____ yes _____ no
3. I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
4. I agree to provide unexpired medications in the original, properly dated and labeled container. I will keep a dosage count and record of expiration date at home and will deliver refills as needed. I will promptly pick up any unused/expired medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of school closing in June 2025
5. How do you want to handle epinephrine administration during times when your child is attending a school function/event after school hours (clubs/sports, etc.), on during off school activities during day/overnight field trips? Please check one.
    a. ☐ COP (Carries on Person @ all times)
    b. ☐ FTAS (Carries only on field trips and afterschool activities)
    c. ☐ DNC (Does not carry Chaperone to carry and be with student during entire event)
    d. ☐ Parent to attend field trip/activity

_____ _____ _____

Parent/Guardian Signature **Relationship to student** **Date**

If your child's allergy action plan includes an antihistamine such as Benadryl/Zyrtec please complete the second parent permission sheet on the reverse of this form. If a nurse is not on a field trip Benadryl can not be given, an EpiPen will be used and 911 called.

FOR HEALTH OFFICE USE ONLY

Allergy history on file: ☐ Grade 06 Date: _____ ☐ Grade 09 Date: _____

Possible Side effects and Required Storage Conditions: See attached form(s) Name of Medication: _____

Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____

Date_____ Date: _____ Date: _____ Date: _____

PARENT/GUARDIAN CONSENT FOR PRESCRIPTION
ANTIHISTAMINE MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

I consent to have the school nurse or his/her designee administer antihistamine medication as prescribed by my child's physician.

1. I give permission to allow the administration of antihistamine to my child by the school nurse or in the absence of the school nurse. I also allow the school nurse to share with appropriate school personnel information relative to this medication administration plan.

2. I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

3. **I understand that there will be no antihistamine available for afterschool and field trip activities when a nurse is not present. Epinephrine will be utilized when no antihistamine is available.** This is in accordance with Board of registration in Nursing Regulation #244 CMR 3.05 which prohibits the delegation of PRN antihistamine medications when there is not a nurse present.

4. Benadryl/Zyrtec will be utilized from the stock medications at school. If parents have another preference, then the parent will provide the antihistamine in its original container.

☐ **Use stock Antihistamine (Benadryl/Zyrtec).**

☐ **Parent will provide antihistamine.** I agree to provide unexpired medications in the original, properly dated and labeled container. I will keep a dosage count and record of expiration at home and will deliver refills as needed. I will promptly pick up any unused/expired medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up on the last day of school closing in June 2025

_____ _____ _____

Parent/Guardian Signature **Relationship to student** **Date**

FOR HEALTH OFFICE USE ONLY

Allergy history on file: ☐ Grade 06 Date: _____ ☐ Grade 09 Date: _____

Possible Side effects and Required Storage Conditions: See attached form(s) Name of Medication: _____

Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____

Date: _____ Date: _____ Date: _____ Date:_____

Contract for Permission to Carry and Self Administer Epinephrine Auto-injector 2024-25

Name of Student: _____ Grade: 6 7 8 9 10 11 12

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their Epinephrine Auto-injectors with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. The school nurse and your child complete the rest of the form. Please contact the School Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the medication that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that he/she will be responsible for carrying and self-administering this medication under the contract agreement level checked below. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement

Parent/Guardian Signature: _____ Date: _____

CONTRACT AGREEMENT: Check One

- ☐ **COP (Carries on person at all times)**
- ☐ **FTAS (Field Trips/Sports/ After School Activities)**
- ☐ **DNC (Does Not Carry. Chaperone/coach/club leader carries and student to be with them for duration of event)**
- ☐ **Other to be determined by Sch. Nurse:** _____

To be completed by School Nurse and Student		
Physicians order for this medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, time it needs to be administrated and purpose of the medication	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use/administration of medication using an Epinephrine trainer and agrees to carry only the amount of medications required.	Yes ☐	No ☐
Student agrees to be responsible to provide and carry his/her own Epinephrine on field trips/after school activities/sports. If student forgets to bring his/her Epinephrine, & there is no backup in H.O. then 911 will be called if medication is required	Yes ☐	No ☐
Student agrees that after administering this medication he/she will immediately inform a faculty member call 911.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s) with others.	Yes ☐	No ☐
Student agrees to maintain a backup Epinephrine in the health Office	Yes ☐	No ☐
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.	Yes ☐	No ☐

Expiration date on Medication in Health office is _____ Expiration date on Medication student is carrying is _____

Amount of medication student can carry ☐ One Epinephrine Autoinjector ☐ Two Epinephrine Autoinjectors

I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: Date:

This student ☐ does ☐ does not demonstrate the required responsibilities
This student ☐ may ☐ cannot carry/self-administer the medication.

Nurse Signature: Date:

Allergy Health History 2024-25 (to be completed by parent/guardian)

Name: _____ **Grade:** 6 7 8 9 10 11 12 **Date:** _____

1. **Does your child have a diagnosis of an allergy from a healthcare provider?** ☐ No ☐ Yes
2. **History and Current Status**

a. What is your child allergic to?

☐ Peanuts ☐ Tree Nuts (walnuts, pecans, etc.)
☐ Eggs ☐ Insect Stings
☐ Milk ☐ Fish/Shellfish
☐ Soy ☐ Chemicals
☐ Latex ☐ Vapors
☐ Other: _____

b. Age of student when allergy discovered: _____
c. How many times has student had a reaction?
☐ Never ☐ Once ☐ More than once, explain:
_____
d. Explain their past reaction(s):
_____
e. Symptoms: _____
f. Are the allergy reactions: ☐ Same ☐ Better ☐ Worse

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 allergen? ☐ Secs. ☐ Mins. ☐ Hours ☐ Days
   d. Please check the symptoms that your child experienced in the past:

Skin:	☐ Hives	☐ Itching	☐ Rash	☐ Flushing	☐ Swelling (face, arms, hands, legs)
Mouth:	☐ Itching	☐ Swelling (lips tongue, mouth)			
Abdominal:	☐ Nausea	☐ Cramps	☐ Vomiting	☐ Diarrhea	
Throat:	☐ Itching	☐ Tightness	☐ Hoarseness	☐ Cough	
Lungs:	☐ Shortness of breath	☐ Repetitive Cough	☐ Wheezing		
Heart:	☐ Weak pulse	☐ Loss of Consciousness			

4. **Treatment**

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

5. Self-Care

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

6. Family/Home

a. Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes
b. Has your child ever needed to administer that Epinephrine? ☐ No ☐ Yes
c. Do you feel your child needs assistance in coping with his/her food allergy? ☐ No ☐ Yes
d. How do you want to handle?

Field trips: _____ Overnight Field trips: _____
After school activities: i.e., sports/clubs: _____
Food events: _____ Travel to and from school: _____
Gym: _____

e. Do you want your child to have a "Contract to Carry" their Epinephrine ☐ No ☐ Yes, please check status of contract: ☐ Carries on Person (will always carry)
☐ Field trips and after school act. only
☐ Do not want to carry (teacher/coach, will be students buddy on all trips)

7. General Health

a. How is your child's general health other than their allergy? _____
b. Does your child have other health conditions? _____
c. Hospitalizations? _____
d. Does your child have a history of Asthma? ☐ No ☐ Yes
e. If yes, does he/she have a rescue metered dose inhaler? ☐ No ☐ Yes
f. What is the Name of your Childs Inhaler? _____
g. Does he/she have an Asthma Action Plan ☐ No ☐ Yes
h. Please list any and all medications (prescribed/over the counter) that your child is currently taking:
_____
i. Please add anything else you would like the school to know about your child's health.

Parent/Guardian Signature: _____ Date: _____

Please be aware that if you feel your child has needs beyond the physicians and nurse's allergy action plans you may call Guidance for a 504 Plan

Health Care Plan Potential for Life Threatening Allergy (LTA)

Student Name: _____

DOB: _____Grade: _____

Parent Name: _____

Cell Phone: _____ Other Phone: _____

Emergency Contact: _____

Cell Phone: _____ Other Phone: _____

Health Care Provider/Phone: _____

Allergist/Phone: _____

Known allergy to: _____

Date of last allergic reaction: _____

Has your child ever received Epinephrine: Yes__ No__

If yes, please describe symptoms & treatment_____

_____

Pertinent Medical History: _____

Medication: _____ Dosage: _____

Frequency/time taken: _____ Route: _____

Must sit at allergy awareness table at lunch: Yes__ No__

My child rides the bus: Yes__ No__ If yes, Bus#___

Before/After-school activities: _____

I give permission for my child's allergy information (AAP/HCP) and picture to be shared with school faculty (teachers, field trip chaperones, transportation faculty, sports, and after school activities/club advisors, etc.) for the safety of my child. Yes _____ No _____

Nursing Diagnosis:
Potential for alteration in safety due to anaphylaxis due to LTA.

Goals:

- Prevent accidental exposure to allergens at school & possible anaphylaxis.
- Increase student's independence with the management of their personal space.

Parent/Guardian will:

- maintain communication with the school nurse regarding any changes in the allergy/medical status.
- provide all appropriate medical documentation, provider's orders, parent consent & medication administration plan form, and any other allergy management information.
- supply Epinephrine auto-injector.
- educate and discourage their child from sharing food in school.
- be responsible for all communication with school staff for child's before/after school activities.

Student will:

- not share food while in school and/or on the school bus.
- check with an adult if any concerns about food and/or if they feel they are having allergy symptoms.
- maintain control over their personal space in the classroom/cafeteria and practice good hand hygiene before/after eating.

Classroom staff will:

- encourage the student to wash hands before/after eating.
- complete annual allergy awareness and Epinephrine Auto-injector training by the school nurse.
- inform students/visitors of classroom guidelines regarding food allergy safety.
- notify parents if food is being served in the classroom for any reason.

School Nurse will:

- document in PowerSchool that student has LTA & Epinephrine Auto-injector.
- ensure that school staff are trained in the use of Epinephrine Auto-injector and familiar with LTA's.
- send Epinephrine Auto-injector on field trips that occur during school hours and delegate to trained staff member(s).
- ensure there is an allergy aware table in the cafeteria for student use if needed
- ensure bus drivers are instructed in LTA awareness and trained to use Epinephrine Auto-injector per AMSACS policy.

Parent/Guardian: _____ Date:_____

School Nurse: _____ Date: _____