Medication Authorization Form Year_____

Student Name: _____ School: _____Grade: _____

TO BE COMPLETED BY PHYSCIAN:

Diagnosis for Medication: _____

Medication Name	Dose	Time To Be Given *If **PRN** please indicate how often medication can be given*	Route	Side Effects	Special Instructions (Such as "take with food" or "crush pill")

Start Date: _____ **Stop Date:** _____

If **PRN** (as needed) list symptoms /conditions under which medication is to be given: _____

_____ _____ _____

Physician Signature **Date** **Physician Printed Name**

To be completed by parent/guardian:

I am giving permission for my child_____to receive the above medication/treatment at school according to school district policy and for the physician and school district staff to share information regarding my child's medication needs.

_____ _____

Parent/Guardian Signature Date

Please turn completed and signed form into office when completed.

Updated 6/2019

POLICY CONCERNING ADMINISTRATION OF

MEDICATIONS/MEDICAL PROCEDURES BY SCHOOL DISTRICT PERSONNEL

HOLD HARMLESS AND INDEMNIFICATION

In consideration of the agreement of persons at the District to administer medication and/or medical procedures to _____ _____, as requested by me and prescribed by a physician. I, on my own behalf, and on behalf of any other person associated with me, hereby agree to hold harmless and indemnify the Southgate Community School District, its Board of Education members, administrators, teachers, secretaries, and other employees, from any and all claims, damages, liabilities, demands, actions, causes of action, which may hereafter be asserted by any person, corporation, or other entity, against the parties listed above or against any other person associated with the Southgate Community School District under any legal theory based upon or arising out of circumstances related in any way to administration, by the District personnel, of medications or medical procedures to _____.

Witnesses:

_____ Signature of Parent/Guardian

_____ Telephone No. (Home)

_____ Emergency Contact Name

Date

_____ Emergency Contact Number

Please turn completed and signed form into office when completed.

Updated 6/2019

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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:_____

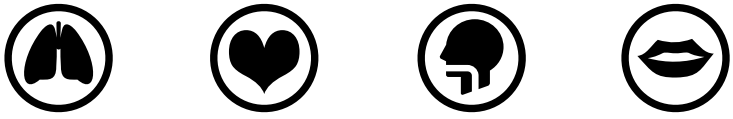
THEREFORE:

☐ 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

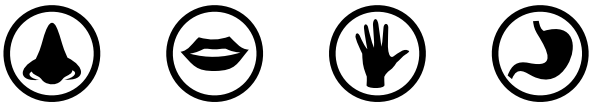
OTHER
Feeling something bad is about to happen, anxiety, confusion

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): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

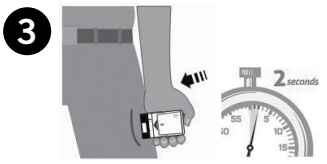
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

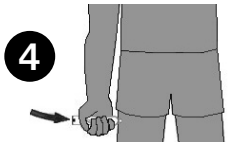
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



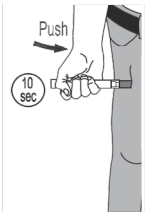
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 ADRENACLICK®), 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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Special Diet Statement

Why am I being asked to fill out this form?

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet.* According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

Sponsors are not required to accommodate special dietary requests that are not a disability. This includes requests related to religious or moral convictions or personal preference. **If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.**

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. **Updates to this form are required only when a participant's needs change**.

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-free milk without a physician's signature. Lactose-free milk served must meet meal pattern requirements for the program.

Submit this completed special diet statement to: _____

Participant Information:

Participant's Full Name: _____ Today's Date: _____

Date of Birth:_____

Name of School/Center/Site Attended: _____

Parent/Guardian Name: _____

Home Phone Number: _____ Work Phone Number:_____

Required Information: Dietary Accommodation

1. List the food to be avoided:

   _____

2. Briefly explain how exposure to this food affects the participant:

   _____

3. List foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other:_____

☐ Tube Feeding Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

☐ Other Dietary Modification or Additional Instructions (Describe): _____

*School Nutrition Program –7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4).

Required Signature

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner. The medical person signing it should keep a copy of this document in his/her records.

Prescribing Authority Credentials (print):_____Date:_____

Signature:_____Clinic/Hospital:_____

Phone Number:_____Fax Number: _____

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Statement by signing the Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to_____**(program name)** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. **Optional**: My permission to release this information will expire on_____**(date)**. This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian:_____Date: _____

OR Participant's Signature (Adult Day Care ONLY): _____

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (https://www.ocio.usda.gov/sites/default/files/docs/2012/Complain_combined_6_8_12.pdf), (AD-3027) found online at: How to File a Complaint (https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint), and at any USDA office, or write a letter addresse d to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary of Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410
2. fax: (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.