MAGNUS HOW-TO GUIDE

SAINT PHILIP'S EPISCOPAL SCHOOL

Upon login, you will be prompted to watch a tutorial video.

To Do

Test Test

Class of 2024 (PK-3)

You have requirements to complete on your To Do List.

Complete now

Wait! View this tutorial to learn how to use your account.

01:36

HD

Close

SECURE AREA

PAA Privacy Policy

Here you will be able to log off and change your password.

Click here to complete requirements.

Welcome, Test Test

Need Help?

Front Desk

Go to Front Desk

To Do

Test Test

Class of 2024 (PK-3)

You have requirements to complete on your To Do List.

Complete now

Student grade listed here

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STUDENT PRIVACY PLEDGE SIGNATORY

TRUSTe Certified Privacy

HIPAA Privacy Policy

Tracker Summary Homepage

Student Health Tracker

Go to Front Desk

Test Test

Class of 2024 (PK-3)

Due Date
August 7

Tracker Summary
Test is 0% complete.

Print blank forms

You have **12** requirement(s) in your to do list.

	Requirement	Blank Form	Action	Answer	Status
To Do	**Vital Health Record** *This is a required form that must be completed by a parent/guardian.*		Fill it out		
To Do	**Consent to Treat Form** *This is a required form that must be completed and signed by a parent/guardian.*		Fill it out		
To Do	**DH3040 (yellow form) - School Entry Health Exam Instruction Form** *This is a required form that must be completed and signed by a parent/guardian and physician.* Physician's signature required		Turn it in		
To Do	**DH680 (blue form) Florida Certificate of Immunization Form** *This is a required form that must be completed and signed by a physician.* Physician's signature required		Turn it in		
To Do	**Does your child take prescription medications during the school day?** **Prescription Medication Form** *This is a required form that must be completed and signed by a parent/guardian and physician.* Physician's signature required		Yes No		
To Do	**Does your child have asthma?** **Asthma Action Plan Form** *This is a required form that must be completed and signed by a physician.*		Yes No		

Must be submitted upon initial entry to school

Immunizations – this form can only be provided by pediatrician, cannot print.

Required for all students

To print all required blank forms (These require both a parent and physician signature)

Test Test

Class of 2024 (PK-3)

Due Date
August 7

Tracker Summary

Test is 0% complete.

Print blank forms

Select the forms to print below:

It is strongly recommended that you answer any yes/no questions from your "To Do" list before printing your forms. Questions answered "no" do not require a printed form.

Select all Deselect all

- [ ] DH3040 (yellow form) - School Entry Health Exam Instruction Form - Physician's signature required
- [ ] DH680 (blue form) Florida Certificate of Immunization Form - Physician's signature required
- [ ] Prescription Medication Form - Physician's signature required
- [ ] Asthma Action Plan Form - Physician's signature required
- [ ] Allergy Action Plan Form - Physician's signature required
- [ ] Diabetes Action Plan Form - Physician's signature required
- [ ] Seizure Action Plan Form - Physician's signature required
- [ ] Over-The-Counter Medication Form - Physician's signature required

You must select at least one form to print.

Submit only if applicable to your child

ACTION PLANS

You can also print forms by clicking on this icon

To Do

Does your child take prescription medications during the school day?
Prescription Medication Form
This is a required form that must be completed and signed by a parent/guardian and physician.
Physician's signature required

Yes No

To Do

Does your child have asthma?
Asthma Action Plan Form
This is a required form that must be completed and signed by a physician.
Physician's signature required

Yes No

To Do

Does your child have allergies?
Allergy Action Plan Form
This is a required form that must be completed and signed by a parent/guardian and physician.
Physician's signature required

Yes No

To Do

Does your child have diabetes?
Diabetes Action Plan Form
This is a required form that must be completed and signed by a parent/guardian and physician.
Physician's signature required

Yes No

To Do

Does your child have a seizure disorder?
Seizure Action Plan Form
This is a required form that must be completed and signed by a parent/guardian and physician.
Physician's signature required

Yes No

If you choose YES for any of these items, you will be taken to the form that needs to be signed by you and your child's physician

ST. PHILIP'S EPISCOPAL SCHOOL

MEDICAL AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

Student's Name: ______________________ **Date of Birth:** ________ **Weight:** _____ **Lb/**_____ **Kg**

Known Allergies: ______________________________________ **Grade:** ______________

Listed below are over-the-counter medications that are available in the school health office. These are intended for safe, symptomatic relief of minor conditions that do not warrant exclusion from school. The health office will administer such medication **only** with the physician's signature on file and parent approval. Regardless of submitted orders, parent/guardian will be contacted prior to the administration of any of the medications listed below.

If you do not wish for your child to receive any of the listed medications below during the school day, please circle No to all and sign below:
Parent/Guardian Name: ______________________ Signature: ______________________ Date: __________

If you do wish for your child to be able to receive one or all of the medications listed below, please continue on to the instructions below.

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER:

IF STUDENT IS 5 YEARS OR YOUNGER *OR* WEIGHS LESS THAN 24 LB, a prescribed dosage must be included for any approved oral medications to be administered. All other students will receive dosage according to weight/age unless otherwise specified.

MEDICATION	DOSAGE	ROUTE	FREQUENCY	PURPOSE	PERMISSION	
Acetaminophen (Tylenol) 160mg/5ml		ORAL	Every 4 hours As Needed	Pain/Fever	YES	NO
Ibuprofen (Motrin/Advil) 100mg/5ml		ORAL	Every 6-8 hours As Needed	Pain/Fever	YES	NO
Diphenhydramine (Benadryl) 12.5mg/5ml		ORAL	Every 4-6 hours As Needed	Allergy Symptoms, Rash or Hives	YES	NO
Loratadine (Claritin) 5mg/5ml		ORAL	Once a day As Needed	Allergy Symptoms, Rash or Hives	YES	NO
Cetirizine (Zyrtec) 1mg/1ml		ORAL	As Needed	Allergy Symptoms, Rash or Hives	YES	NO
Cough Drop (Menthol 5.8 mg) **only for ≥ 6 yrs**	1 lozenge	ORAL	As Needed	Cough/Sore Throat	YES	NO
Bacitracin Antibiotic Ointment	1 application	Topical	As Needed	Minor cuts, scrapes, burns	YES	NO
Benadryl Cream (Diphenhydramine hydrochloride 1%, Zinc acetate 0.1%)	1 application	Topical	As Needed	Insect bites, minor burns, sunburn, minor skin irritations/rashes	YES	NO
Hydrocortisone Cream	1 application	Topical	As Needed	Itching due to minor skin irritations/rashes	YES	NO
Sterile Eye Wash (Purified Water 98.5%)	Flush as Needed	Ophthalmic	As Needed	Flushing of foreign materials from eyes	YES	NO

Permission is hereby granted to the School Nurse and/or designated school personnel to assist or perform the administration of each medication listed on this Authorization Form to my child during the school day. I understand that there is no liability on the part of St. Philip's Episcopal School, its personnel, or agents for any damages as a result of the administration of this medication(s) to my child. I understand that the School nurse cannot change the dosage or frequency of any medication; signed instructions are needed from the prescribing physician using the Prescription Medication Order form. Medication orders must be renewed annually. Changes to any medication requires a new form.

______________________ ______________________ __________
Parent/Guardian Name **Parent/Guardian Signature** **Date**

______________________ ______________________ __________
Physician Name **Signature** **Date**

______________________ ______________________
Physician's Phone Number **Physician's Address**

This form allows nurse to administer the listed over the counter medications – it serves as the doctor's order

Parent will still be called prior to administering any medication

If you do not wish for your child to receive any of these medications, sign this section & you may submit without a doctor's signature.

Dosages to any approved oral medications must be included for students 5 years or younger or if he/she weighs less than 24 lbs

Parent and MD signature required if medications are approved for administration at school.

St. Philip's Episcopal School

Permission for Prescription Medications

(includes non-prescription medications not listed on the Over-the-Counter Medications form)

Parent/guardian and physician signature are required unless prescribed for a short term (i.e. Amoxicillin for 10 days - pharmacy-labeled bottle will suffice in these scenarios).

Student Name: ______________________ **Date of Birth:** __________ **Grade:** __________

Please list all current medication(s) your student takes daily or as needed below that may be needed during school hours.

Are these medication(s) to be administered at school? ☐ Yes ☐ No

Permission is hereby granted to the School Nurse and/or designated school personnel to assist or perform the administration of the listed medication(s) to my child during the school day or during off-campus trips as specified. Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted. I understand that: (1) there is no liability on the part of St. Philip's Episcopal School, its personnel, or agents for any damages as a result of the administration of this medication(s) to my child; (2) the medication supplied to the School must be brought to the School only by a responsible adult and kept in the School Clinic unless otherwise specified. Students are prohibited from carrying any medication at school (with the exception of asthma inhalers, epinephrine auto-injectors, insulin and Glucagon when appropriate); and (3) all medications must be in their original labeled container (please ask pharmacy for separate labeled bottle/package for school). Medication orders must be renewed annually. Changes to any medication requires a new authorization form. The parent/guardian will be responsible for ensuring that medicines provided to the school have not expired. It is your responsibility to notify the school in writing when there is a change in medication regimen. Medication will only be administered if a completed authorization form has been submitted. Please refer to the next page for more details on how medications should be provided to the school.

Medication 1: ______________________ Taken with Food? ☐ Yes ☐ No

Dosage: __________ Route: __________ Time (s) of administration: __________

Self-carry? ☐ Yes ☐ No Self-administer? ☐ Yes ☐ No

Medication 1: ______________________ Taken with Food? ☐ Yes ☐ No

Dosage: __________ Route: __________ Time (s) of administration: __________

Self-carry? ☐ Yes ☐ No Self-administer? ☐ Yes ☐ No

Medication 1: ______________________ Taken with Food? ☐ Yes ☐ No

Dosage: __________ Route: __________ Time (s) of administration: __________

Self-carry? ☐ Yes ☐ No Self-administer? ☐ Yes ☐ No

Parent/Guardian Name **Parent/Guardian Signature** **Date**

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

Physician's Phone Number **Physician's Address**

If your child takes a medication routinely or as needed during the school day, this form will be required.

Please be sure all **action plan medications** are listed on this document (including over the counter medications even if also present on the OTC medication form).

- The brand & type of medication matches on the orders, action plan and what is delivered to the school nurse

The nurse and/or designated school personnel cannot administer any medication without a doctor's order <u>and</u> parent approval

Allergy Action Plans

Please include student's picture here

Please ensure all items on both pages are completed

Allergy and Anaphylaxis Emergency Plan

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Child's name: ______________________ **Date of plan:** ____________

Date of birth: ___/___/_____ **Age** _____ **Weight:** ________kg ________ lb

Child has allergy to ______________________________

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis **What to look for**	**Give epinephrine!** **What to do**
If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**. • Shortness of breath, wheezing, or coughing • Skin color is pale or has a bluish color • Weak pulse • Fainting or dizziness • Tight or hoarse throat • Trouble breathing or swallowing • Swelling of lips or tongue that bother breathing • Vomiting or diarrhea (if severe or combined with other symptoms) • Many hives or redness over body • Feeling of "doom," confusion, altered consciousness, or agitation ☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): ______________. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.	1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. • Ask for ambulance with epinephrine. • Tell rescue squad when epinephrine was given. 3. Stay with child and: • Call parents and child's doctor. • Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. • Antihistamine • Inhaler/bronchodilator

For Mild Allergic Reaction **What to look for**	**Monitor child** **What to do**
If child has had any mild symptoms, **monitor child.** Symptoms may include: • Itchy nose, sneezing, itchy mouth • A few hives • Mild stomach nausea or discomfort	Stay with child and: • Watch child closely. • Give antihistamine (if prescribed). • Call parents and child's doctor. • If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses
Epinephrine, intramuscular (list type): ______________________ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)
Antihistamine, by mouth (type and dose): ____________________ (*Use 0.15 mg, if 0.10 mg is not available)
Other (for example, inhaler/bronchodilator if child has asthma): ____________________

Parent/Guardian Name ____________ Parent/Guardian Signature ____________ Date ________

Physician Name ____________ Physician Signature ____________ Date ________

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: ______________________ **Date of plan:** ______________________

Additional Instructions:

Contacts

Call 911 / Rescue squad: ____________________

Doctor: ______________________ Phone: ____________

Parent/Guardian: ______________________ Phone: ____________

Parent/Guardian: ______________________ Phone: ____________

Other Emergency Contacts

Name/Relationship: ______________________ Phone: ____________

Name/Relationship: ______________________ Phone: ____________

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Student Health Tracker

Date of expiration listed here

Can view previous answers here

Can print forms, update status, or view form history here

Requirement	Status	Answer	Actions
Vital Health Record	✔ 08/09/2023	View Vital Health Record	⚙
Consent to Treat Form	✔ 08/09/2023	View Record	⚙
DH3040 (yellow form) - School Entry Health Exam Instruction Form	✔	View Record	⚙
DH680 (blue form) Florida Certificate of Immunization Form	✔	View Record	⚙
Prescription Medication Form	✔ 08/09/2023	Not Applicable	⚙
Asthma Action Plan Form	✔ 08/09/2023	Not Applicable	⚙
Allergy Action Plan Form	✔ 08/09/2023	Not Applicable	⚙
Diabetes Action Plan Form	✔ 08/09/2023	Not Applicable	⚙
Seizure Action Plan Form	✔ 08/09/2023	Not Applicable	⚙
Over-The-Counter Medication Form	✔ 08/09/2023	View Record	⚙
Authorization for Pickup	✔ 08/09/2023	View Record	⚙