Date Medication Received: _____Lot #_____ Exp Date: _____

Permission for Medication/Procedure

For School Use:
- ☐ Prescription
- ☐ Routine
- ☐ OTC
- ☐ PRN

Name:	DOB:	Grade:	Teacher:
Medication/Procedure:	Dosage:		Route:
Purpose of Medication/Procedure:	Frequency:	Allergies:	
Possible Side Effects:	Medical Condition:		ICD-10:
Is medication controlled? ☐ YES ☐ NO	Time of day medication to be given at school: (lunches vary from 10:30 – 1:00)		
Note any special storage requirements: ☐ Refrigerate ☐ Other: _____	Anticipated number of days medications needs to be given at school: ☐ Until end of current school year ☐ _____ weeks ☐ _____ days		
If applicable (for emergency medications): ☐ **May repeat dose in 15 minutes, if no improvement in condition is noted**	**If applicable:** ☐ **May pre-medicate with rescue inhaler if presents to health room after physical activity.**		

When possible, medications should be administered by a parent/guardian before or after school hours. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school must be provided by a parent/guardian in the original labeled container. Prescription medications must have a label provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administrations, and the name, address and phone number of the prescribing health care provider. Non-prescription medications will be administered with parent/guardian written permission according to the directions on the container.

***By signing below you indicate agreement with the Emergency Action Plan located on the back of this form. (if applicable)**

Signature of Physician:	**Date:**
Type or Print Name of Physician:	Office Phone: Office Fax:

I give permission for my child who is listed above to be given the above medication/procedure. I authorize the school nurse, the principal, or his/her designee (who may be non-nursing personnel) to assist with the medication/procedure. A record of the trainees will be kept on file by the school nurse. I understand that it is my responsibility to provide any medication and/or supplies that my child may need during school or school related activities. I give permission for the school nurse or school administrator to contact the health care provider named above, the pharmacist who filled the prescription and/or their designated employees to discuss this medication/procedure and my child's health. I give permission for the "Permission for Medication/Procedure" form to apply if I transfer my child to another school in this same school district during this same school year. I understand that the school may require that I agree to the school district rule about medications/procedures before the medicine/procedure may be given at school. Neither the school district nor its personnel will be responsible for the occurrence of any adverse drug reaction when the medication/procedure has been given/performed in the manner prescribed above. I understand that I am responsible for notifying the school if my child's medications/procedure changes in any way. **Your child may qualify for a written Individualized Healthcare Plan (IHP). The school nurse will be writing this plan for your child based on these orders. If you do not wish for your student to have an IHP, please contact your child's school nurse. If your child rides a bus and you would like his/her emergency medication on the bus and the bus driver trained for this medication, please contact your child's school nurse to make arrangements.**

Signature of Parent/Guardian:	**Daytime Phone Number:**	**Date:**

⇨ SEE OTHER SIDE

TO BE COMPLETED BY PARENT/GUARDIAN:

<table>
<tr><th colspan="3">FOR ASTHMA MEDICATIONS ONLY:</th><th colspan="3">FOR ALLERGY MEDICATIONS ONLY:</th></tr>
<tr><th colspan="3">Asthma Emergency Action Plan</th><th colspan="3">Allergy Emergency Action Plan</th></tr>
<tr><td colspan="2">How long has your child had asthma?</td><td></td><td colspan="3">What happens to child during reaction?
☐ Swelling ☐ Hives ☐ Itching ☐ Difficulty Breathing
☐ Other: _____</td></tr>
<tr><td colspan="2">Does your child recognize signs/symptoms of asthma?</td><td>☐ YES
☐ NO</td><td colspan="3">Reactions have occurred from:
☐ Eating ☐ Touching ☐ Smelling
☐ Other: _____</td></tr>
<tr><td colspan="2">Has your child been hospitalized for asthma?</td><td>☐ YES
☐ NO</td><td>Has child had any serious reactions?</td><td colspan="2">☐ YES ☐ NO</td></tr>
<tr><td colspan="3">Dates of hospitalizations:</td><td>If YES, how many?</td><td colspan="2"></td></tr>
<tr><td colspan="3">Triggers:</td><td>Date of last serious reaction:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Does your child have any restrictions relating to activities and/or school related functions? (PE, Athletics, etc.)
(*If YES, MD note required)</td><td>☐ YES*
☐ NO</td><td colspan="3">If there has been an exposure to an allergen and
NO symptoms:
▪ Monitor student
▪ Notify parent
▪ Notify School Nurse</td></tr>
<tr><td>If you see this:</td><td colspan="2">Do this:</td><td>If you see this:</td><td colspan="2">Do this:</td></tr>
<tr><td>▪ Wheezing
▪ Frequent Cough
▪ Complaint of Chest Tightness or
▪ Difficulty breathing
▪ Able to talk in complete sentences</td><td colspan="2">▪ Administer or Assist with prescribed bronchodilator or other medication as ordered
▪ Notify parent
▪ Notify School Nurse
▪ Stay with student
▪ Return student to class or send home as indicated</td><td>Mild Symptoms:

SKIN:
▪ A few hives
▪ Mild itching
GUT:
▪ Mild nausea
▪ Stomach discomfort</td><td colspan="2">▪ Give antihistamine
▪ Stay with student
▪ Monitor
▪ Notify Parent</td></tr>
<tr><td>▪ Constant cough
▪ Struggles or gasps for breath
▪ Difficulty talking
▪ Skin of chest and/or neck pulling in with breathing
▪ Lips or fingernails are gray or blue
▪ Decreased level of consciousness</td><td colspan="2">▪ Call 911
▪ Administer or Assist with prescribed bronchodilator or other medications as ordered
▪ Stay with student
▪ Notify School Nurse
▪ Notify Parent
▪ Notify administrator</td><td>Severe Symptoms after Exposure:
LUNGS:
▪ Shortness of breath, wheezing, constant coughing
HEART:
▪ Pale, blue, faint, weak, dizzy, confused
THROAT:
▪ Tight, hoarse, trouble breathing/swallowing
MOUTH:
▪ Tongue swelling, lip swelling
SKIN:
▪ Hives all over body
GUT:
▪ Severe abdominal cramps, vomiting, diarrhea
Or a combination of symptoms from different body areas</td><td colspan="2">▪ GIVE EPINEPHRINE IMMEDIATELY
▪ Stay with student
▪ Give bronchodilator (inhaler) if ordered
▪ Call 911
▪ Notify parent
▪ Notify school nurse
▪ Notify administrator

*Inhalers and antihistamines are not to be depended upon to solely treat anaphylactic reactions. Symptoms can rapidly become more severe.
When in doubt, use epinephrine</td></tr>
<tr><td colspan="2">▪ Refer to anaphylaxis plan if student has allergies
▪ Encourage slow, deep breaths
▪ Stay with student and remain calm
▪ If there is no rescue medication at school, immediately call the parent/guardian.
▪ If a parent/guardian is unable to pick up student or bring medication and student is in distress, notify them that EMS will be called to treat student.
▪ Notify administrator and school nurse</td><td></td><td></td><td colspan="2"></td></tr>
</table>

Date	Notes	Initials

Print Name: _____ Signature with Credentials: _____ Initials: _____