Edmonds School District

HS-501
Authorization for Administration of Medication for Life-Threatening Allergic Reaction at School and School Sponsored Events

RCW 28A.310.320, RCW.28A.210.260 and 270, WAC 110-300-0215, 3420 SB Policy, 3420P SB Procedure

Student's Name: _____ DOB: _____ Grade: _____ School Year: _____

School: _____ Parent / Guardian Name: _____

LICENSED HEALTH CARE PROVIDER (LHCP) ORDERS – EMERGENCY MEDICATIONS

THIS PORTION TO BE COMPLETED BY LHCP WITH PRESCRIPTIVE AUTHORITY (e.g., MD, DO, ARNP, DDS, etc.)

LIFE-THREATENING ALLERGY: _____ ❑ **Ingestion** ❑ **Touch** ❑ **Inhalation**

Other Allergies:_____ Date of last reaction, if known:_____

Anaphylaxis signs: trouble breathing, hives, swelling of lips/tongue/throat, hoarse voice, nausea, vomiting, dizziness, feeling of doom
If school nurse is NOT AVAILABLE epinephrine WILL be given by trained staff without delay for ANY allergy symptoms or suspected/known exposure to allergen(s). Student must be monitored by medical personnel or parent/guardian and may NOT stay at school.

INJECTION CALL 911:

❑ **Epinephrine (0.3 mg - approximately 66 lbs and above) Injection to Outer Thigh Muscle**
❑ **Epinephrine (0.15 mg - approximately 33 lbs- 66 lbs) Injection to Outer Thigh Muscle**
❑ **Epinephrine (0.1 mg - approximately 16.5 lbs - 33 lbs) Injection to Outer Thigh Muscle**

Student trained to: Self-Carry ❑ Yes ❑ No Self-Administer ❑ Yes ❑ No

❑ **Repeat Epinephrine in_____ minutes if EMS has not arrived and if additional medication available.**

ORAL:

❑ **Antihistamine_____by mouth _____mg**

Student trained to: Self-Carry ❑ Yes ❑ No Self-Administer ❑ Yes ❑ No

ASTHMA:
Yes ❑ No ❑

If history of asthma and wheezing, shortness of breath, or complaints of chest tightness with allergic reaction:

❑ **Rescue Inhaler** ❑ **2 puffs** ❑ **4 puffs of _____** ❑ **Use spacer**

Student trained to: Self-Carry ❑ Yes ❑ No Self-Administer ❑ Yes ❑ No

SIDE EFFECTS: Epinephrine: increased heart rate Antihistamine: sleepiness Inhaler: increased heart rate, shakiness

LICENSED HEALTH CARE PROVIDER (LHCP) ORDERS – NON ANAPHYLAXIS MEDICATIONS

Use this section for asthma/allergy symptoms not related to epinephrine administration

Diagnosis/ Condition	Medication	Dosage	Route	Time/Frequency	Side Effects	*Self Carry	*Self Administer
						Y N	Y N
						Y N	Y N
						Y N	Y N

***Marking "yes" to self-carry/administer indicates that the LHCP has provided instruction in the purpose and appropriate method/ frequency of use, and that the student is capable and safe to self-carry and/or self-administer.**

I request and authorize that the above-named student receive the above identified medications in accordance with the instructions indicated beginning ____/____/____ not to exceed current school year and Summer School or otherwise specified____/____/____

LCHP's Signature: _____ Date: _____

Clinic Stamp

LCHP's Name: _____ Phone Number: _____

LCHP's Address: _____ Fax Number: _____

This form must be signed by the parent/guardian.

Parent/Guardian Permission

Parent/Guardian Signature:_____ Date:_____

Student Signature (Self-Carrying):_____ Date:_____

School Nurse Signature:_____ Printed Name:_____ Date:_____

TURN OVER TO COMPLETE FORM *Rev 7/24 AU*

Administration of Medication in School

Medication should be given at school only when necessary. The school health room is staffed only during school hours and does not remain open for the duration of after-school clubs, athletic practices/games, concerts, dances, or other school-sponsored events. If the student must receive prescribed oral or topical medication, eye drops, ear drops, premixed nasal spray medications, or life-saving allergy medication during school hours or when the student is under the supervision by district staff and for official school events, the principal will designate and the school nurse will train and delegate school staff to administer medications and provide a plan to access medications. The medication to be given at school must have a written order signed by a Licensed Healthcare Professional (LHCP) working within the scope of their prescriptive authority and have a parent/guardian signature. Parents/guardians are responsible for ensuring medication and treatment supplies are available for their students. The medication must be in the original, properly labeled container. This includes any over the counter medication. Parents/guardians wishing for their student to self-carry and self-administer medications independently must provide signed medication orders from their LHCP explicitly stating this plan. Note students are not permitted to self-carry controlled substances. Students in K-5 grades are not recommended to self-carry. Students that self-carry medications does not relieve the parents/guardians of the annual health update, medication authorization orders, and health care plan each school year. Whenever possible the parent/guardian and LHCP are urged to design a medication schedule for administering medication if the student is participating in school sponsored activities outside of the normal school day hours. Edmonds School District accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHCP order. Edmonds School District does not share private health information with outside entities without explicit written consent.

In addition, RCW 28A. 210.260, RCW 28A.210.355, and RCW 28A.210.330 allow parents of students with epilepsy or diabetes to select a “parent designated adult” to provide parent-directed nursing care in school.

Prior to participating in field trips, athletics, clubs, etc., parents/guardians of a student with healthcare conditions should consult with the school nurse to develop care considerations for the out-of-building environment.

The health care plan does not extend and apply to non-school sponsored activities. If a student attends extended before/after school care programs, or participates in non-school sponsored activities, parents/guardians are responsible for notifying that entity’s program leadership of their student’s healthcare and medication needs.

This portion to be completed by Parent/Guardian

I the Parent/Guardian Understands:

When notified by school personnel that medication has expired, no longer is required as a course of treatment, or at the end of the school year, I am responsible for collecting the medication from the school or understand that it will be destroyed. Edmonds School District assumes no responsibility for self-carried and self-administered medications. In the event a safety issue arises, the school nurse has the right to notify the parent/guardian/student and discontinue the self-medication privilege. The student’s health plan will be modified annually to reflect current health needs. I will provide the health information, medication authorization orders, unexpired medication in a properly labeled container and treatment supplies.

Optional: ❑ By checking this box I hereby give consent to have non-controlled medication returned home with student.

Student participates in:

- ❑ Athletics
- ❑ Music
- ❑ After-School Clubs
- ❑ Other School-Sponsored Activities _____

My signature below indicates that I have read and understand and will abide by the medication policy.

Signature of Parent/Guardian: _____ Date: _____

Student Signature (Self-Carrying):_____ Date: _____