LETTER TO PARENTS
MEDICATION POLICY

TO: **Parents/Guardian of** _____

FROM: **School Health Clinic**

DATE: _____

SUBJECT: **Medication Policy**

To protect your child's safety, the clinic staff will adhere to the following medication policy. It is required that **BOTH** the parent **AND** prescriber signatures are on file before any prescription **OR** non-prescription medication (depending on the school/district policy) is administered. This includes all medications including such over-the-counter products as Tylenol, Advil, etc.

Although this may cause some inconvenience, we feel that this policy is best for the continued protection of your child, and must be followed. **If we do not have your written permission and the written permission of your prescriber, the medication will not be given.** Permission forms can be obtained by contacting the clinic staff.

In order for your child to receive any medication at school, please conform with the following:

- A written request must be obtained from the prescriber and the parent/guardian. This request must include the name of the medication, dosage, time it is given during school hours, and duration. Forms are available at the school.
- A signed Prescriber and Parent Request for the Administration of Medication at School is required in order to dispense medication.
- The medication must be in its original container and, and if an over-the-counter medication, the bottle must be new with an unbroken seal. All medications must have a fixed label which indicates the student's name, name of medication, dosage, method of administration, time of administration and time interval of dosages.
- When the empty prescription bottle is returned to you, please bring the refill to school promptly.
- The medication and the signed permission form must be brought to the school by the parent or guardian. **Students may not bring medication to school.**
- Please include a photo of your child with the permission form.
- New Request forms must be re-submitted each school year, and are **necessary for any changes in medication orders.**
- If your child is taken off medication or will no longer receive it at school, please put your request in a dated, written note as soon as possible, accompanied by a prescriber's signed order to discontinue the medication. If the medication is not picked up by parents from the health aide or school office within 30 days, it will be properly disposed of.
- Medication will not be administered without a signed order from the prescriber or Prescriber and Parent Request for the Administration of Medication at School.

Please contact the building principal or clinic staff if you have any questions. Thank you for your cooperation.

PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

***** One Medication per Form *****

Student Photo

School _____.

Student _____ Grade/Rm_____

Address _____

City/State/Zip _____

Name of Medication and Dosage _____

Times of Day to be Administered_____

Number of Times/Intervals Medication is to be Administered_____

Date to Begin Medication_____ Date to End Medication_____

Adverse/Severe Reaction that Should be Reported to Physician _____

Special Instructions for Administration of Medication_____

This medication can be safely administered by non-medical personnel ☐ Yes No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours ☐ Yes No

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

_____ _____

Prescriber's Printed Name Tel

_____ _____

Prescriber's Signature Date

Please regard my signature below as my assurance that I release _____ _____ School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Printed Name Tel

_____ _____

Parent's Signature Date

ALLERGY ACTION PLAN

Drs. Carly Wilbur & Jamie Wood **USE 1 FORM PER CHILD FOR EACH ALLERGEN**

Student Photo

Student _____ School _____.

DOB _____ Age____ Weight ____ Grade/Rm _____

Allergy to _____

START DATE: _____ **END DATE:** _____

Student has asthma. ❑ Yes ❑ No (If yes, higher chance of severe reaction)

Student has had anaphylaxis. ❑ Yes ❑ No

Student may carry epinephrine. ❑ Yes ❑ No (if yes, complete next page)

Student may give him/herself medicine. ❑ Yes ❑ No (If student refuses/is unable to self-treat, an adult must give medicine.)

IMPORTANT REMINDER

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

For Severe Allergy and Anaphylaxis **What to look for** 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.***	**Give epinephrine!** **What to do** 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** 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	**Monitor child** **What to do** Stay with child and: • Watch child closely. • Give antihistamine (if prescribed). • Call parents and child's doctor. • If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")

Medication/Doses

Epinephrine autoinjector, intramuscular (list type): _____ Dose: ❑ 0.15 mg ❑ 0.30 mg

Antihistamine, by mouth (type and dose): _____

Other (for example, inhaler/bronchodilator if student has asthma): _____

_____ _____ _____ _____

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Emergency Contacts/Relationship Telephone number

1. _____ _____
2. _____ _____
3. _____ _____

******(To be completed ONLY if student will be carrying an Epinephrine Autoinjector)******

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with ORC 3313.718/8313.141)

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is not prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07

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SEIZURE ACTION PLAN

Student Photo

School _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student _____ Birthdate _____ Grade/Rm. _____

EMERGENCY CONTACTS

	Name	Relationship	Telephone number
1.			
2.			
3.			

Treating Physician _____ Tel _____

Significant Medical History _____

Allergies _____

Triggers or warning signs _____

SEIZURE EMERGENCY PROTOCOL

A "seizure emergency" for this student is defined as: Start Date _____ End Date _____

- ☐ Seizure lasting > _____ minutes
- ☐ _____ or more Seizures in _____ hour(s)
- ☐ Other _____

SEIZURE EMERGENCY PROTOCOL: ***(CHECK ALL THAT APPLY AND CLARIFY BELOW)***

- ☐ CONTACT NURSE/CLINIC STAFF AT _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other _____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency Medication/ Instructions: _____

Call 911 if

- ☐ Seizure does not stop within _____ minutes of giving Emergency medication
- ☐ Child does not start waking up within _____ minutes after seizure stops (NO Emergency medication given)
- ☐ Child does not start waking up within _____ minutes after seizure stops (AFTER Emergency medication is given)
- ☐ Seizure does not stop by itself or with VNS (Vagal Nerve Stimulator) within _____ minutes

Following a seizure

- ☐ Child should rest in clinic.
- ☐ Child may return to class (specify time frame _____)
- ☐ Notify parent immediately.
- ☐ Send a copy of the seizure record home with child for parents.
- ☐ Notify physician.
- ☐ Other

Seizure Information - Student may experience some or all of the listed symptoms during a specific seizure.

Seizure Type(s)	*Description*	
☐ Absence	•Staring •Eye blinking	•Loss of awareness •Other _____
☐ Simple partial	•Remains conscious •Distorted sense of smell, hearing, sight	•Involuntary rhythmic jerking/twitching on one side •Other _____
☐ Complex partial	•Confusion •Not fully responsive/unresponsive	•May appear fearful •Purposeless, repetitive movements •Other _____
☐ Generalized tonic-clonic	•Convulsions •Stiffening •Breathing may be shallow	•Lips or skin may have blush color •Unconsciousness •Confusion, weariness, or belligerence when seizure ends •Other _____
☐ Myoclonic	•Quick muscle jerks	•Sudden unprotected limb or body jerks
☐ Atonic	•Sudden head drop	•Sudden collapse of body to ground
☐ Non-Seizure Psychogenic Events	Description:	

Seizure usually lasts_____ minutes and returns to baseline in _____ minutes.

Triggers or warning signs _____

Call parents under the following circumstances

1. _____

2. _____

Basic Seizure First Aid
• Stay calm & track time • Keep child safe • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious • Record seizure in log
For tonic-clonic (grand mal) seizure:
• Protect head • Keep airway open/watch breathing • Turn child on side

A Seizure is generally considered an EMERGENCY when
• A convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Student has repeated seizures without regaining consciousness • Student sustains a head injury during episode • Student has a first-time seizure • Student is injured or has diabetes • Student has blue/grey color change • Student has breathing difficulties • Student has a seizure in water

Special Considerations and Safety Precautions (regarding school activities, sports, trips, etc.)

Signatures

_____ _____

Parent/Guardian Signature Date

_____ _____

Physician Signature Date

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Reviewed by Dr. Carly Wilbur

ASTHMA ACTION PLAN for SCHOOL

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Student Photo

Student_____ DOB_____

School_____ Grade/Rm_____

PARENT/GUARDIAN EMERGENCY CONTACT INORMATION:

Parent/Guardian-1 (name/relationship):_____ Phone:_____

Parent/Guardian-2 (name/relationship):_____ Phone:_____

Asthma Triggers_____ Spacer: _____YES_____NO

Does the student use an Epi-pen: YES / NO

Green Zone: Doing Well

Symptoms: Breathing is good, no cough or wheeze, can play and run

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT
FOR ASTHMA WITH EXERCISE, TAKE:		

Yellow Zone: Caution. Child exhibiting some problems breathing

Symptoms: Cough, mild wheeze, tight chest, shortness of breath, problems playing, exposure to known trigger

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT

☐ Can repeat dose every 4 hours as needed. If symptoms unresolved or getting worse, follow **red zone**, seek medical attention and contact the parent.

Red Zone: Emergency. Quick-relief medicine has not helped

Symptoms: very short of breath, trouble talking/walking, nasal flaring, use of accessory muscles, blue or gray discoloration of the lips or fingernails. Obtain medical attention right away!

MEDICINE	DOSE
	Number of puffs_____
	Can repeat every_____ minutes up to _____ times

FOLLOW THE YELLOW AND RED ZONE INSTRUCTIONS FOR RESCUE MEDICATION ACCORDING TO THE STUDENT'S SYMPTOMS.

Healthcare Provider: (circle correct response)

YES / NO: Student is PERMITTED to CARRY an inhaler and SELF-MEDICATE at school with the understanding that he/she is to report to the school clinic if symptoms do not improve.

Signature of Prescriber_____ Date_____

Signature of Parent/Guardian_____ Date_____