OCEANSIDE PUBLIC SCHOOLS | School #6 Early Learning Center
25 Castleton Court, Oceanside, NY 11572

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Dear Parents/Guardians:

There have been several issues regarding Medication in school. Please review the school's policy below. If you have any questions, please call the school nurses' office at 516-594-2347.

REQUIREMENTS FOR ADMINISTRATION OF MEDICATION FOR A CHILD DURING SCHOOL HOURS

If your child has to take a **prescription or over-the-counter medication** during the school day, the following procedure is necessary.

1. Medications may be administered in school only in compliance with New York State regulations.

2. Medications will be given ***only*** with a written order from a licensed health care professional and with written permission from the parent/guardian of the student. (This includes all medications such as prescription drugs, medicated cough drops, ear drops, ointments, ADVIL AND TYLENOL).

3. The physician's order can be on a prescription or they can complete Administration of Medication in School form (can be picked up in the nurse's office). This information must include:
    - Diagnosis or condition being treated
    - Dosage, frequency and route of medication
    - Information regarding the drug, such as its use and possible side effects
    - Physician's name, address, telephone number and license number

4. The medication must be in its **original container** (bearing a pharmacy label). Pills placed in an envelope or separate container cannot be administered.

5. The medication will be kept in the School Nurse's office in a locked cabinet.

6. It is strongly recommended that all medications that can be given outside school hours, without deleterious effects to the child, should not be administered during school hours.

7. **ONLY MEDICATION DELIVERED TO THE SCHOOL NURSE BY THE PARENT/GUARDIAN WILL BE ACCEPTED. MEDICATIONS MUST NOT BE TRANSORTED ON THE BUS BY THE STUDENT.**

8. All medication must be picked up at the nurse's office PRIOR TO THE LAST DAY OF SCHOOL OR THEY WILL BE DISCARDED.

Sincerely,

Julie McGahan

Julie McGahan
Principal

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PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled, original container from the pharmacy. I understand that the school nurse, or other designated person, will administer the medication.

Signature:_____

Address: _____

Telephone: Home _____ Cell _____ Work _____

TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, as listed below, receive the following medication:

Name: _____ Date of Birth: _____

Diagnosis: _____

Name of medication: _____

Prescribed dosage, frequency, and route of administration _____

Time to be taken during school: _____ Duration of treatment: _____

Possible side effects/adverse reactions: _____

_____

Other recommendations: _____

Name of licensed prescriber and title: (please print) _____

Prescriber's signature: _____ Date: _____

Address: _____ Phone: _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

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

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

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1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

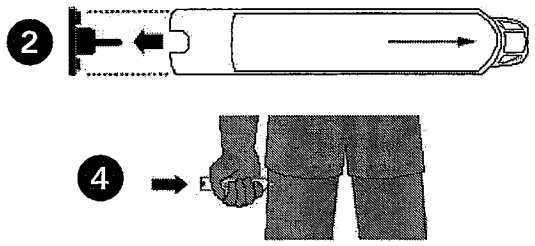
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

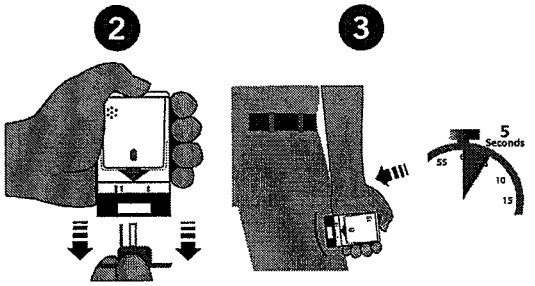
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



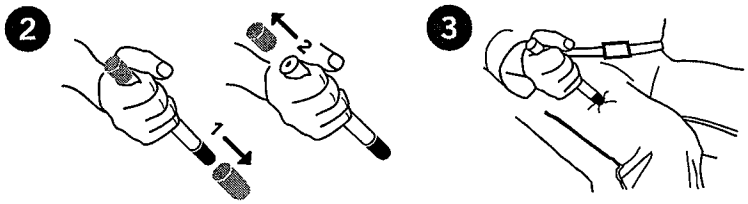
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

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