

## Emergency Action Plan and Order: Severe Allergy in School

<b>School Name</b>	<b>School Phone #</b>	<b>Fax:</b>	<b>For School Use Only</b>
			<b>Date Received/Receiver's Signature:</b> <b>Medication Received?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
<b>Student's Name (Please print.)</b>	<b>Student's Date of Birth</b>		<b>Date Approved/Nurse's Signature</b> <b>Entered in EHR?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
<b>Parent/Guardian: Please read both pages of the Action Plan. Sign and date the bottom of both pages to show your agreement.</b>			<input type="checkbox"/> Student Self Carries
			<input type="checkbox"/> Medication in Health Room
			<input type="checkbox"/> Medication in Classroom

**Important Information about Medication Administration in CMS Schools**

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| <ul style="list-style-type: none"> <li>When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.</li> <li>Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: off-label use, research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.</li> <li>Unless changed in writing, this plan will be used for the entire school year within which it was written.</li> <li>Medications are given by a nurse or trained CMS staff.</li> </ul> | <ul style="list-style-type: none"> <li>No medication will be given at school until this authorization has been approved by a school nurse.</li> <li>New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.</li> <li>Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.</li> <li>Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.</li> <li>The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.</li> </ul> |
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<b>Healthcare Provider's Name / Address / Phone / Fax (please print or use stamp)</b>	<b>Parent/Guardian Contact Information (please print)</b>	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools" in this action plan. I give permission for my child to receive the medications noted in this plan during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.



## School Asthma Action Plan/Medication Authorization Form



Mecklenburg County Public Health.

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Parent's/Guardian's Name (print)

Signature

Date

<b>Student's Name:</b>	<b>Student's Date of Birth:</b>
<b>List of Allergies:</b>	

SEVERE SYMPTOMS	MILD SYMPTOMS
<p style="text-align: center; border-top: 1px solid black; border-bottom: 1px solid black;"><b>Administer Epinephrine Immediately</b></p> <p><b>Lung</b> Wheezing, trouble breathing, repetitive cough</p> <p><b>Heart</b> Weak pulse, dizziness, faintness, pale or bluish skin, chest tightness, low blood pressure</p> <p><b>Throat</b> Tight or hoarse throat, difficulty swallowing or breathing, drooling</p> <p><b>Mouth</b> slurred speech, swelling or tingling of lips, mouth, or tongue</p> <p><b>Skin</b> Many hives (raised, reddened rash) over the body, widespread redness, severe itching, swelling of face</p> <p><b>Stomach</b> Repetitive vomiting, severe diarrhea, stomach pain</p> <p><b>Other</b> Anxiety, confusion, feeling of impending doom</p> <p><b>Combination of symptoms from different body areas</b></p>	<p><b>Nose</b> Itchy or runny nose, sneezing, nasal congestion</p> <p><b>Mouth</b> Itchy mouth</p> <p><b>Skin</b> A few hives, mild itch</p> <p><b>Stomach</b> Mild nausea or discomfort</p> <hr/> <p>For <b>Mild Symptoms</b> from <b>More Than One</b> system area: <b>Administer Epinephrine</b></p> <hr/> <p>For <b>Mild Symptoms</b> from a <b>Single System</b> area, <b>Follow the directions below:</b></p> <ol style="list-style-type: none"> <li>1. Antihistamines may be given, if ordered by health care provider</li> <li>2. Stay with the student and notify parents/emergency contact</li> <li>3. Watch for changes, if symptoms worsen administer epinephrine as ordered by health care provider</li> </ol>

Name of Medication	Dosage	Route	Possible Side Effects
Epinephrine: _____	<input type="checkbox"/> 0.15 mg <input type="checkbox"/> 0.3 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg	<input type="checkbox"/> Intramuscular injection <input type="checkbox"/> Nasal Spray	
Antihistamine: _____	_____ mg	Oral	

**If Epinephrine is given (e.g., Auvi-Q, Epinephrine Auto-Injector, EpiPen, Neffy Nasal Spray):**

1. **Stay with the student. Monitor alertness and breathing. Provide CPR if necessary.**
2. **Have another person: Call 911 immediately. Notify school nurse, parent/guardian and principal.**
3. **If symptoms are getting worse or not improving after 5 minutes, administer a one-time second dose in the anterolateral aspect of the opposite thigh (not in the same thigh as the first dose).**

In my professional opinion, the medication noted above is necessary for this student if an allergic reaction occurs at school.		
Health Care Provider Name (print):		
Health Care Provider Signature:		Date:

I have reviewed this Emergency Action Plan and agree with this plan. I agree to school staff being trained to administer the medication.	
Preferred Hospital:	

Parent/Guardian Signature:		Date:
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Student's Name	Student's Date of Birth	Name of Medication

### CMS ELIGIBILITY REQUIREMENTS FOR SELF-MEDICATION

Students with chronic conditions such as asthma, diabetes, severe allergies, and those who require frequent doses of non-prescription products, may be eligible to self-medicate. Self-administration of a controlled substance will be considered in rare instances where potentially harmful medical episodes may occur. For self-medication, students: 1) must be mentally, emotionally, and physically capable of self-administering medication, 2) must have been instructed in proper use and safe-keeping of their medications, 3) must demonstrate mature and responsible behavior using their medication 4) must keep their medication secure on their own person or in some other manner agreed upon with the school nurse and the school administration, and 5) must not share medication with or display to other students. The privilege of being allowed to self-medicate may be taken away if there is any just cause. Failure to follow CMS policies and regulations may result in disciplinary actions as noted in the Student Code of Conduct. The CMS Board of Education, its designees, and agents, do not assume responsibility for self-medication by students. Additional details are noted in CMS Policy JLCD/Regulation JLCD-R.

### HEALTHCARE PROVIDER

The student named above meets the CMS eligibility requirements for self-medication. This student is capable of, has been instructed on the procedures for and has demonstrated the skill to self-administer this medication as directed in Section 1 of this form. This student will not require adult supervision while taking this medication. **Check applicable items below:**

- This medication is a controlled substance.
- Please allow this student to self-administer this medication while at school during school hours.
- This student should always carry this medication with him/her during the school day, while at school-sponsored events, or while in transit to or from school or school-sponsored activities.

Healthcare Provider Signature:	Date:
Healthcare Provider (Print Name):	

### PARENT/LEGAL GUARDIAN

My child is capable of self-medicating and meets the CMS eligibility requirements. I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. I will ensure my child carries the correct and non-expired medication to school. If this medication is for a life-threatening emergency such as anaphylaxis or asthma, I agree to provide a backup supply of the medication to be kept at school in a location to which my child has immediate access to assure the medication is available if needed. I release the Charlotte-Mecklenburg Board of Education, their agents, and employees from all liability whatsoever that may result from my child carrying or taking this medication at school. I understand that information about this medication and my child's health may be shared with other school staff and agents of the school to help assure my child's safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health.

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian (Print Name):	

### STUDENT

I am capable of taking this medication on my own. I agree to take this medication as ordered. I will keep it safe and out of the sight of others when I am not using it. I will not let others hold or use my medication or medical supplies. I understand that I will be disciplined under the CMS Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school sponsored activities. I understand that I may lose the privilege of self-administering my medication if I do not follow these rules. I understand that if I self-administer my medication and my symptoms do not improve, I will notify the school nurse or other CMS staff.

Student Signature:	Date:
Student (Print Name):	

### SCHOOL NURSE

I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication and has the correct and non-expired medication with them at the time of signage of this document. I have informed this student that he or she must tell an appropriate staff member whenever he or she has used the medication at school.

Nurse Signature:	Date:
Nurse (Print Name):	

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Mecklenburg County Public Health

**PRINCIPAL / DESIGNEE**

I have reviewed this request and approve this student for self-administering this medication.

Principal/Designee Signature <u>and</u> Print Name:	Date:
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