Fill out all forms that apply and return to Richmond Community High School via fax (804) 780-4423 or hardcopy by February 06, 2026 . PARENTS and HEALTH CARE PROVIDERS must sign EACH APPLICABLE FORM.

Please note all HIGHLIGHTED areas of these forms. This medical form packet includes:

THIS PAGE: fill in your child's name, complete the checklist, and sign where indicated **on this page. This page/checklist below is REQUIRED FOR ALL STUDENTS.**

FORM 1: "REQUEST FOR MEDICATION/TREATMENT DURING SCHOOL HOURS" (1 page)
This form is REQUIRED for *all* students who will need *ANY medication*s on Minimester. RPS/RCHS cannot give your child *any* medications, including common over-the-counter medications such as Tylenol, Advil, or Claritin, ***without this completed and signed form.***

- You will need to bring your student's over-the-counter and prescription medications *to the nurse at RCHS* the week prior to Minimester. All such medications must be *listed on the form.*
- Students may NOT bring *any* medication in their own bags. This is a violation of SCORE.
- Teachers will administer your child's approved, parent-provided medications on Minimester.

FORM 2: SEIZURE ACTION PLAN (2 pages)
This form is REQUIRED for all students with a seizure disorder.

FORM 3: ALLERGY & ANAPHYLAXIS EMERGENCY PLAN (INCLUDES EPI PEN) (1 page)
This form is REQUIRED for all students with severe allergies and students who need EPI-pens. *If your child needs an EPI-PEN, you must send TWO EPI-PENS with your child for Minimester.*

FORM 4: VIRGINIA ASTHMA ACTION PLAN (2 pages)
This form is REQUIRED for all students with asthma.

PLEASE COMPLETE THE CHECKLIST BELOW, AND ALL APPLICABLE FORMS IN THIS PACKET.

THIS PAGE / checklist below is REQUIRED FOR ALL STUDENTS, regardless of medication needs and medical conditions; *all students must have this first page on file.* Complete other forms if applicable.

STUDENT NAME (print): **CIRCLE the correct class: FRESHMAN SOPHOMORE JUNIOR SENIOR**	
☐ Yes ☐ No	My student will need to be able to take **prescription or over-the-counter medications** while on Minimester and I am **completing/returning Form 1, *with a health care provider's signature.***
☐ Yes ☐ No	My student has a **seizure disorder** and I am **completing/returning Form 2, *with a health care provider's signature.***
☐ Yes ☐ No	My student has **severe allergies / needs an EPI pen** and I am **completing/returning Form 3, *with a health care provider's signature.***
☐ Yes ☐ No	My student has **asthma** and I am **completing/returning Form 4, *with a health care provider's signature.***
☐ Yes	**I am aware that my student will not receive *any* medications without Form 1, and, that my student may not bring *any* medications to Minimester themselves. *Complete, sign and return this page to RCHS even if you checked "no" for all four previous questions.***
PARENT SIGNATURE / date:	

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FORM 1: REQUEST FOR MEDICATION/TREATMENT DURING SCHOOL HOURS: THIS FORM IS REQUIRED for all minimester students who will need medication of any kind.

Medication will not be administered if this form is altered and/or is not filled out completely.

Richmond City Public Schools require that if medication/treatments are to be taken by a student while he/she is in school or participating in school activities, the school ***MUST*** have the following information completed and on file in the health clinic:
1. A signed order from the health care provider renewed yearly 2. A signed consent from the parent or guardian.
3. The medication in the original pharmacy container. THIS APPLIES TO ANY MEDICATION, PRESCRIPTION OR OVER THE COUNTER

All medication must be kept in the school health office. It is the responsibility of the student to come to the clinic for administration at the proper time. *Student possession and self-administration of certain medications are permitted for conditions such as Diabetes, Asthma, and Allergy.

To be completed by the Health Care Provider:

Student: _____Grade: _____ School: Richmond Community High School

Medication/Treatment: _____ Dosage, Frequency, Route:_____

Diagnosis: _____

Medication/Treatment Required: School Year Short Term _____Date required: _____

Special Instructions, Side Effects, Comments:

_____

_____

Health Care Provider Signature: _____

Health Care Provider PRINTED Name: _____

Address: _____

Telephone:_____Fax_____

Date:_____

To Be Completed by Parent or Guardian:
I request that school personnel administer the above medication/treatment ordered by the health care provider, according to the directions provided. I understand that the nurse is not always available and that an appointed trained designee may be responsible for administering my child's medication/treatment. I authorize a representative of the school to share information regarding this medication/treatment with the above health care provider and school staff as necessary for the student's health and safety at school. I understand and agree to comply with the school's policies and procedures as stated on the back of this form.

Signature of Parent/Guardian _____ Date: _____

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FORM 2: SEIZURE ACTION PLAN (SAP) Complete both sides of this form if the student has a SEIZURE CONDITION. .

Name: _____ **Birthday:** _____
Address: _____ **Phone:** _____
Parent/Guardian: _____ **Phone:** _____
Emergency Contact/Relationship: _____ **Phone:** _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during minimester trip (check all that apply) ☐

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Contact school nurse
- ☐ Give rescue therapy according to SAP
- ☐ Call 911 for transport to closest hospital
- ☐ Notify parent/emergency contact
- ☐ Other _____

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, #, or length) _____
Name of Med/RX _____ How much to give (dose) _____ How to give _____

If seizure (cluster, #, or length) _____
Name of Med/RX _____ How much to give (dose) _____ How to give _____

If seizure (cluster, #, or length) _____
Name of Med/RX _____ How much to give (dose) _____ How to give _____

Care after seizure

What type of help is needed? (describe) _____ When is student able to resume usual activity? _____

Special instructions

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FORM 2 SEIZURE ACTION PLAN PAGE 2

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History:_____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: □ VNS □ RNS □ DBS Date Implanted _____

Diet Therapy □ Ketogenic □ Low Glycemic □ Modified Atkins □ Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone:_____

Preferred Hospital: _____ Phone:_____

Pharmacy: _____ Phone:_____

Parent signature _____ Date_____

Provider signature _____ Date_____

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FORM 3: ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN (TO INCLUDE EPI PEN): Complete this form if the student has an ALLERGY CONDITION that requires medication or EPI pen. If needed, student must bring two EPI pens on minimester.

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. □ Yes □ No (If yes, higher chance severe reaction)

Child has had anaphylaxis. □ Yes □ No
Child may carry medicine. □ Yes □ No
Child may give him/herself medicine. □ Yes □ No (If child refuses/is unable to self-treat, an adult must give medicine)

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

☐ **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**.

Medicines/Doses

Epinephrine, intramuscular (list type): _____

Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)* ☐ 0.15 mg (13 kg to less than 25 kg) ☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

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

Parent/Guardian Authorization Signature _____ **Date** _____

Physician/HCP Authorization Signature_____ **Date** _____

Additional Instructions:_____
_____
_____
_____

Contacts	**Phone**
Doctor:	
Parent/Guardian:	
Parent/Guardian:	
Emergency Contact:	
Emergency Contact:	

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FORM 4: VIRGINIA ASTHMA ACTION PLAN: Complete both sides of this form if the student has ASTHMA.

School: Richmond Community High School

Effective Dates:		
Name		**Date of Birth**
Health Care Provider	**Emergency Contact**	**Emergency Contact**
Provider Phone:	**Phone:**	**Phone:**

Asthma Triggers

☐ Colds ☐ Smoke (tobacco/incense) ☐ Pollen ☐ Dust ☐ Acid reflux ☐ Exercise	☐ Strong odors ☐ Mold/moisture ☐ Stress/emotions ☐ Animals:_____ ☐ Pests (rodents / cockroaches) ☐ Other:_____	**Season** ☐ Fall ☐ Winter ☐ Spring ☐ Summer
Asthma Severity: □ Intermittent Persistent: □ Mild □ Moderate □ Severe		

GreenZone: Go! Take these CONTROL Medicines every day at home, school, or on minimester

You have ALL of these: • Breathing is easy • No cough or wheeze • Can work and play • Can sleep all night Peak flow: _____ to _____ (More than 80% of Personal Best) Personal best peak flow:	**Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible.** ☐ No control medicines ☐ Advair _____, ☐ Alvesco_____, ☐ Arnuity ____, ☐ Asmanex ____ ☐ Breo _____, ☐ Budesonide ____, ☐ Dulera _____, ☐ Flovent ____, ☐ Pulmicort ____ ☐ QVAR Redihaler ____, ☐ Symbicort _____, ☐ **MDI**: ____ puff (s) ____ times per day or **Nebulizer** Treatment: ____ times per day ☐ Singulair/Montelukast take _____mg by mouth once daily
For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise (If asymptomatic not < than every 6 hrs**):** ☐ Albuterol ☐ Xopenex ☐ Ipratopium	

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Form 4 Asthma Action Plan page 2

Yellow Zone: Caution! Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these: • Cough or mild wheeze • First sign of cold • Tight chest • Problems sleeping, working, or playing **Peak flow:** _____ to ____ (60% - 80% of Personal Best)	□ Albuterol □ Levalbuterol (Xopenex) □ Ipratropium (Atrovent) **MDI:** _____ puffs with spacer every _____ hours as needed □ Albuterol 2.5 mg/3m1 □ Levalbuterol (Xopenex) □ Ipratropium (Atrovent) 2.5mg/3m1 **Nebulizer Treatment:** one treatment every _____ Hours as needed

Red Zone: DANGER! Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these: • Can't talk, eat, or walk well • Medicine is not helping • Breathing hard and fast • Blue lips and fingernails • Tired or lethargic • Ribs show **Peak flow: <** _____ (Less than 60% of Personal Best)	□ Albuterol □ Levalbuterol (Xopenex) □ Ipratropium (Atrovent) **MDI:** _____ **every 15 minutes** for **THREE treatments** □ Albuterol 2.5 mg/3m1 □ Levalbuterol (Xopenex) □ Ipratropium (Atrovent) **Nebulizer Treatment**: one nebulizer treatment **every 15 minutes,** for **THREE** treatments

I give permission for school personnel to follow this plan, SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER administer medication and care for my child, and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child. With HCP authorization & parent consent inhaler will be located with student (self-carry). PARENT/Guardian signature_____ Date_____	Student may carry and self-administer inhaler at school and on minimester. MD/NP/PA SIGNATURE:_____ DATE _____