Delphos City Schools

MEDICATION INFORMATION FORM

FOR THE ADMINISTRATION AND/OR SELF-POSSESSION OF EPINEPHRINE DELIVERY SYSTEMS

Many students are receiving medication under a doctor's supervision. It is important that the school be aware of the effects the medication might have or is having on the school performance of the students. School personnel are occasionally requested to administer the medication. Under these circumstances, it is necessary that specific physician's recommendations be made available to the school.

NAME OF STUDENT: _____ DATE OF BIRTH: _____

BLDG. _____ GRADE: _____ TEACHER : _____

STUDENT ADDRESS: _____

NAME OF MEDICATION: _____

LIFE THREATENING ALLERGY: _____

MEDICATION IS TO START: _____ END DATE:_____

TIMES ADMINISTERED: _____

OTHER MEDICATIONS STUDENT IS TAKING: _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OR STORAGE OF MEDICATION: _____

_____

REACTIONS: The physician/pharmacist is urged to list potential reactions the student might have to this medication:

_____

In the event the student is unable to administer the anaphylaxis medication or the medication does not produce the expected relief from the student's anaphylaxis, school employees should follow the following procedures: _____

_____

_____

List any severe reactions that may occur to the child using the epinephrine delivery system that should be reported to the physician: _____

Other special instructions from the physician: _____

The parent agrees to provide a back-up dose of the anaphylaxis medication to the school principal, or if a school nurse is assigned to the student's building, the school nurse. During school hours, it is my understanding that the school secretary, principal, school nurse AND/OR the above stated child will administer the prescribed medication according to the specified physician's recommendation. The school nurse may contact this physician at any time for information about my child's condition. I agree to submit a revised statement signed by the prescriber if any of the information provided on this form changes. This form is valid for the current school year only and will serve as a Medical Release Form between school and healthcare provider.

The above stated child has been instructed on proper use, storage, and administration of the prescribed epinephrine delivery system and has demonstrated competency in self administration. ☐ ***Yes*** ☐ ***No***

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

ALLERGY CARE PLAN

STUDENT NAME: _____ DATE OF BIRTH: _____

You have indicated that the above named student currently has **a SEVERE or SERIOUS ALLERGY.** It is important to have at least annual health information when she/he needs help at school. Please complete this form and return it to school, so a plan can be established and shared with appropriate school personnel. It is the responsibility of the parent/guardian to provide necessary special food and medicine needed at school. If you have any questions, please call the school. **REMEMBER TO NOTIFY SCHOOL IMMEDIATELY OF ANY CHANGES IN PHONE NUMBERS, CONTACT PERSONS, ETC.**

Check any life-threatening allergy this student has:

☐ Insect stings – list type: _____ ☐ Food – list type : _____

☐ Animals – list type: _____ ☐ Other – list type: _____

Indicate the signs that are usually present during an allergy attack:

☐ Difficulty Breathing ☐ Very pale skin ☐ Swelling – Where? _____

☐ Rash ☐ Loss of consciousness How much? _____

☐ Nausea ☐ Difficulty swallowing

☐ Flushed Skin ☐ Other: _____

Has emergency medical treatment been needed in the past year for allergies? ☐ No ☐ Yes - When? _____

Allergies currently being treated by: _____ Phone: _____

Are medications needed to control or treat the allergy? List below the medications needed.

Medication	Amount taken	Time of Day	Taken at school [1]

The usual treatment at school for a severe allergic reaction is to:

1. **Observe for inadequate breathing, signs of shock, or unusual swelling.**
2. **When observed, call 911.**
3. **Report to parents.**

Please indicate any additional information[2] _____

_____

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_____

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

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[1]The district medication policy requires parental and physician signature on district forms for all medications administered during school activities.

[2]Any treatments or test and activity restrictions require written directions from the student's physician or primary care provider.