THE Siena SCHOOL®

Montgomery County DHHS Authorization Form for Schools to Administer Medications, Release and Indemnification Agreement

Part I – To Be Completed by the Parent/Guardian

I hereby request and authorize the school personnel to administer prescribed and/or Over The Counter (OTC) medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless the school and any of their officers, staff members, or agents such as nurse delegates from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided the school staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back (or as page 2) of this form and assume the responsibilities as required.

Student: _____ **Birth date:** _____

Prescription: ____**Renewal** _____ **New** If new, the first full day's dosage was given at home on: _____

Allergies _____

List all medication(s) the student is taking, including over-the-counter medication(s): _____

_____

_____ _____ _____

Parent/Guardian Signature **Phone Number** **Date**

Part II – To Be Completed by the Physician for Prescriptions or Over The Counter (OTC) Medications

The Montgomery County DHHS and the School discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before or after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form or as the 2nd page of this form. Please do not use abbreviations.

****I have read the above parent/guardian information and assume the responsibilities as required.**

*****MUST USE A SEPARATE FORM FOR EACH PRESCRIPTION OR OTC MEDICATION*****

Name of Medication: _____ **Diagnosis (write out):** _____

Dosage: _____**Frequency (write out):**_____ **Time(s) to be given at school:** _____

Route of Administration: _____**Effective Dates: From:**_____**To:**_____

Side Effects: _____

If PRN, must specify indication (signs/symptoms): _____

_____ _____

****Physician's Name (Print/Type)** ****Physician Signature** **Phone Number** **Date**

MD Address or stamp: _____**Fax :** _____

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of Emergency med. such as inhalers and EpiPens® must be authorized by the prescriber and school nurse according State medication policy.

****MD Prescriber's authorization** _____**School RN approval** _____

Signature **Date** **Signature** **Date**

Part III – To Be Completed By the School Nurse

_____**Parts I and II above are completed, including signatures.** _____**Medication is properly labeled by pharmacist.**

_____**Medication label and physician order are consistent.** _____**OTC Medication is in manufacturer labeled container.**

School Nurse Signature and Date_____

Information and Procedures

1. No medication will be administered in school or during school-sponsored activities without the parent's/guardian's written authorization and a written physician order. This includes both prescription and over-the-counter (OTC) medications.

2. The parent/guardian is responsible for completing Part I and obtaining the physician's statement on Part II. This is required every school year for each new or continuing order or if there is a change in dosage or time of administration during the school year. (A physician may use office stationery or prescription pad in lieu of completing Part II.) Information necessary includes: child's name, diagnosis, medication name, dosage, time of administration, duration of medication, side effects, physician signature, and date.

3. The medication must be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent/guardian. Under no circumstances will the School administer medication brought to school by a child.

4. All prescription medication must be provided in a container with the pharmacist's label attached. Non-prescription OTC medication must be in the container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician.

5. The first day's dosage of any new medication must have been given at home before it can be administered at school.

6. The parent/guardian is responsible for collecting any unused portion of a medication within one week after expiration of the physician's order or at the end of the school year. Medication not claimed within that time period will be destroyed.

7. Self-administered and/or non-medically prescribed medications are entirely the responsibility of the parent/guardian and not that of The Siena School. Medications without accompanying physician's orders and parental consent will not be stored in the health room.

8. Students may not self-administer controlled substances.

9. A physician's order and parental permission are necessary for self-carry/self-administered emergency medications such as inhalers for asthma and EpiPens® for anaphylaxis. The school nurse must evaluate and approve the student's ability and capability to self-administer medication. It is imperative the student understands the necessity for reporting to the health staff or other school staff that they have self-administered their inhaler without any improvement or have self-administered an EpiPen®, so that 911 may be called.

10. The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

11. **This form applies to overnight trips provided there are no changes.**

Asthma Medication Administration Authorization Form ASTHMA ACTION PLAN for

_____/_____/_____to_____/_____/_____(not to exceed 12 months) Name:_____DOB:_____PEAK FLOW PERSONAL BEST: _____

ASTHMA SEVERITY: ☐ **Exercise-induced** ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent** **List Triggers:**

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: _____
- ☐ Peak flow greater than_____(80% personal best)

Medication	Dose	Route	Frequency

Signature

☐ **Prior to exercise/sports/ physical education**

(Rescue Medication)			

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: _____
- ☐ Peak flow between_____and _____ (50%-79% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in_____minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medications— Take these medications and call 911

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or skin retracts between ribs
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other:_____
- ☐ Peak flow less than_____(50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization with Review by RN

I authorize the school/camp staff to administer the above medications as indicated. Student may self-carry medications (School-age students only) ☐ **Yes** ☐ **No**

Prescriber signature & date: _____

Parent/Guardian signature & date: _____

By signing below, I certify that the student is authorized to self-carry/self-administer medication at school/camp and authorize the student to self-carry/self-administer the medications indicated during school or camp.

Prescriber signature & date: _____

Parent/Guardian signature: _____

Reviewed by DN/RN Health Supervisor

Name: _____

Signature/date: _____

_____

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Asthma Action Plan (continued)

Camper's Name: _____ Date of Birth: _____

Counselor's Name: _____ Group: _____

Camp will:

- ☐ Have staff trained in medication administration onsite
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis, Asthma Signs & Symptoms, and Administration of Inhaler or Nebulizer
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to camp staff
- ☐ Have staff trained on individual emergency plans
- ☐ Ensure staff make every reasonable effort to prevent exposure to known allergens and Asthma triggers
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the camp
- ☐ Provide Physician Authorization Forms and Action Plans
  → for medication, and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide spacer if indicated, as needed by physician
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Come to office to use inhaler prior to exercise
- ☐ Alert nearest adult if they experience any symptoms of Asthma (cough, wheezing, shortness of breath)
- ☐ If self-carrying and self-administering, camper will demonstrate responsibility by carrying their inhaler and notifying adult when they have used it, and committing to not sharing medication with any other person.

Notes:

Revised April 12, 2017

Place Child's Picture Here

HEALTH LINK LLC

Prevention Plan

Student's Name: _____ Date of Birth: _____

Teacher's Name: _____ Room #: _____

ALLERGY TO: _____

_____

Asthmatic? Y/N) _____ (Yes=Higher Risk for Severe Reaction)

School will:

- ☐ A Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to:_____
- ☐ Have staff trained on individual emergency plans
- ☐ School staff will make every reasonable effort to prevent the student's exposure to known allergens
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans
  → for student medication and specific actions plans for emergency care
- ☐ Current, non-expired medications
- ☐ Provide safe snack option to school/classroom
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Make every effort to avoid contact with allergen
- ☐ Alert nearest adult if suspect exposure to allergen
- ☐ Other

Notes:

Place Child's Picture Here

Management of Severe Allergic Reactions & Anaphylaxis

HEALTH LINK LLC

Student's Name: _____ **Date of Birth:** _____
Teacher's Name: _____ **Room #:** _____
ALLERGY TO: _____

Asthmatic? (Y/N) _____ (Yes=Higher Risk for Severe Reaction)

STEP 1: TREATMENT

Symptoms	**Give This Medication**	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but *no symptoms*		
Mouth: itching, tingling, or swelling of lips, tongue mouth		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat *: Tightening of throat, hoarseness, hacking cough		
Lung*: Shortness of breath, repetitive coughing, wheezing		
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progression (several of the above areas affected):		

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE
Epinephrine: inject intramuscularly:

EpiPen® or generic _____ Epipen JR® or generic _____ Auvi-Q _____

Antihistamine: give _____

Other: give _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

Doctor's Name	**Doctor's Phone Number**
Parent's Name	**Parent's Phone Number**
Emergency Contact 1 Name/Relationship	**Emergency Contact 1 Phone Number**

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent Guardian's Signature/Date	**Doctor's Signature/Date**

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

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 seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

❒ Contact school nurse at _____

❒ Call 911 for transport to _____

❒ Notify parent or emergency contact

❒ Administer emergency medications as indicated below

❒ Notify doctor

❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

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

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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Seizure Record

Name _____
Agency _____
Physician (Neurologist) _____

YEAR		DAY																																							
		MONTH																																							
Description	Conscious																																								
	Unconscious																																								
	Confused																																								
	Fell																																								
	Became limp																																								
	Became stiff																																								
	Flush																																								
	Pale																																								
	Cyanotic/blue																																								
Body Movements	Jerking																																								
	Twitching face																																								
	Chewing motion																																								
	Tongue biting																																								
	Excessive drooling																																								
	Eyes rolled back																																								
	Eyes staring																																								
	Eyes blinking																																								
	Wet bed/self																																								
	Bowel movement/seizure																																								
Behavior After Seizure	Sleepy/tired																																								
	Alert																																								
	Confused																																								
	Headache																																								
	Temporary paralysis																																								
	Unsteady walking																																								
	Slurred speech																																								
	Increased activity																																								
	Unusual activity																																								
	Time of Day																																								
	Duration (# min.)																																								
	Staff Initials																																								