AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student

Address

School

Grade

A. I am requesting permission for my child named above to: (Check all that apply)

____ use or receive prescribed medication

____ receive prescribed treatment

____ self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent

Date

Home Telephone

Work Telephone

Medication:

Dosage:

Medication:

Dosage:
PHYSICIAN STATEMENT

To the Physician:

The Corporation requires that all of the following information be provided before it will administer medication or treatment to the student named on the reverse side.

I have prescribed the following medication


Beginning Date __________________________ Ending Date __________________________

Dosage, instructions, or precautions (including possible side effects):


I have prescribed the following treatment


Beginning Date __________________________ Ending Date __________________________

Physician’s Signature __________________________ Telephone __________________________

Printed/Typed Name __________________________ Date __________________________

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):


Principal __________________________
AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(ELEMENTARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student ___________________________ Address ___________________________

School ___________________________ Grade ___________________________

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s)

Medication: ___________________________

Dosage: ___________________________

[ ] self-administer such medication(s) in the presence of an authorized staff member

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. Our physician has instructed that this medication should be administered in the above designated dosage.

E. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent ___________________________ Date ___________________________

Home Telephone ___________________________ Work Telephone ___________________________

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s):

________________________________________

Principal ___________________________ Date ___________________________

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Allergy and Anaphylaxis Action Plan and Medication Orders

Student's Name: 
D.O.B. Grade: 
School: Teacher: 
ALLERGY TO: 
History: 

Asthma: YES (Higher risk for severe reaction) NO 

◊ STEP 1: TREATMENT ◊

SEVERE SYMPTOMS:
One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Hives, itchy rash, swelling, (e.g., eyes, lips)

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rash, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

□ Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms

MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

DOSAGE
Epinephrine: inject intramuscularly using auto-injector (check one): □ 0.3 mg □ 0.15 mg
□ Administer 2nd dose if symptoms do not improve in __________ minutes

Antihistamine: (brand and dose) 
If Asthmatic: (brand and dose) 

Student has been instructed and is capable of carrying and self-administering own medication. □ Yes □ No
Provider (print) Phone Number:
Provider’s Signature: Date: 

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, call 911. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: Phone Number: 

3. Emergency contacts: Name/Relationship Phone Number(s) 
   a. ___________________________ 1) __________ 2) __________
   b. ___________________________ 1) __________ 2) __________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS
I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child. *

Parent/Guardian’s Signature: Date: 
School Nurse: Date: 
Physician/Healthcare Provider Signature: Date: 

*
**Asthma Management Plan & Authorization for Medication**

**To Be Completed by Parent:**
- Patient's Name: __________________
- Date of Birth: ____________
- School: ____________
- Grade: ____________
- School E-mail: __________________
- School Fax (____): ____________
- Parent/Caregiver: __________________
- Phone (H): ____________
- Phone (W): ____________
- Phone (Cell): ____________
- E-mail: __________________
- Emergency Contact: __________________
- Relationship: ____________
- Phone: ____________
- Asthma Care Provider: __________________
- Office Phone (____): ____________
- Office Fax (____): ____________
- (please mark best contact)

**To Be Completed by Asthma Care Provider**

**Rescue (Quick-Relief) Medication:**

**Monitoring**

**Red Zone: Emergency Signs**
- Lips and fingernails are blue or gray
- Trouble breathing and talking due to shortness of breath
- Loss of consciousness

**Red Zone: Danger Signs**
- Very short of breath, or
- Rescue medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

**Yellow Zone: Caution**
- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

**Green Zone: Well**
- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

**Treatment**

- Give rescue medication: 2 4 6 puffs (1 min between puffs) or 1 nebulizer treatment
- Call parent and/or Asthma Care Provider
- Call 911 NOW if:
  1. Unable to reach medical care provider after arriving in the red zone
  2. Child is struggling to breathe and there is no improvement after taking albuterol
  3. May repeat rescue medication every 10 minutes if symptoms do not improve until medical assistance has arrived or you are at the emergency department

- Continue daily controller medications
- Give rescue medication: 2 4 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed
- Wait 10 minutes and recheck symptoms
- If not better, go to RED ZONE
- If symptoms improve, may return to class or normal activity, or

- Parent/School Nurse: If needed, coordinate rescue medications to be given every 4 hours for 2 3 days, if symptoms remain improved
- If symptoms are not gone after 2 3 days, move to the RED ZONE

**Medication**

<table>
<thead>
<tr>
<th>Before Exercise</th>
<th>During Exercise</th>
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<tbody>
<tr>
<td>2 PE/Sports (not to exceed every 4 hours)</td>
<td></td>
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</table>

**Daily Controller Medication**

**Please Print Provider Name**

**Asthma Care Provider Signature**

**Parent Signature**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

**Date**

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[InAC February 2015]

[InAC.org]
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: _______________
Treating Physician: _________________________ Phone: _______________
Significant medical history: _______________________

SEIZURE INFORMATION:

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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Seizure triggers or warning signs: _______________________________________________________

Student's reaction to 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

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 _______
☐ Notify doctor _______
☐ Administer emergency medications as indicated below _______
☐ Other _______

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 (grand mal) seizure:

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

A Seizure is generally considered an Emergency when:

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

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

<table>
<thead>
<tr>
<th>Daily Medication</th>
<th>Dosage &amp; Time of Day Given</th>
<th>Common Side Effects &amp; Special Instructions</th>
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Emergency/Rescue Medication

Does student have a Vagus Nerve Stimulator (VNS)? YES NO

If YES, Describe magnet use

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, trips, etc.)

Physician Signature: ___________________________ Date: ___________
Parent Signature: ___________________________ Date: ___________