Asheville Christian Academy

Request for Medication Administration in School

*****_This form must be completed & signed **each year** by a physician and a parent. This form is also used for off-campus activities, including overnight retreats._

No medication (nonprescription nor prescription) will be administered by school personnel or by student without the written authorization of a health care provider and a parent.

To be completed by physician:

Name of Student: _____ Birthdate:_____ Grade: ____

Medication: (each medication is to be listed on separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: _____

To be given from: (date) _____ through: (date) _____

Purpose of medication: _____Contraindications to administration: _____

Physician's Signature: _____ Date: _____

To be completed by parent:

I hereby give permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Asheville Christian Academy School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

I will furnish medication for use at school in a properly labeled container (Nonprescription medication must have student's name on bottle. Prescription medication must be in pharmacy labeled bottle). I will replace the medication when it expires.

Parent/Guardian's Signature: _____

Telephone Number: _____ Date: _____

School Nurse Signature: _____ Date received: _____

*Based on school policy students are <u>not allowed</u> to carry and/or self-administer any medications (nonprescription nor prescription) with the exception of students with diagnosed life threatening allergies, students with asthma, students with diabetes or students with chronic conditions which have been discussed with school nurse.

*Form may be faxed to school nurse, Kristin Moyers RN, at 828-581-2218.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

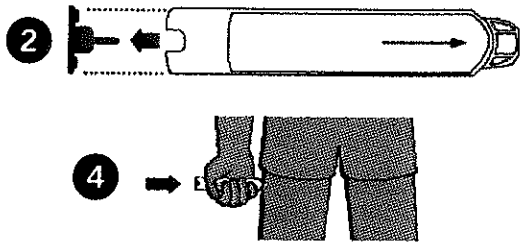
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM MAY BE FAXED TO SCHOOL NURSE, KRISTIN MOYERS, RN 828-581-2218

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

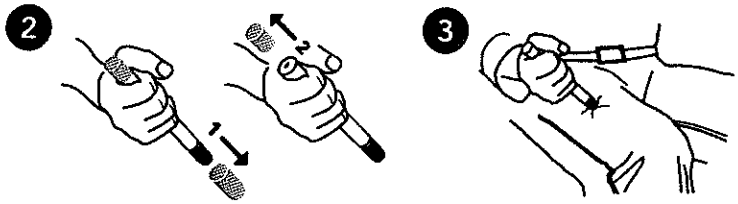
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

Asthma Action Plan

DATE: _____ /_____ /_____ PATIENT NAME _____

WEIGHT: _____ PARENT/GUARDIAN NAME _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: _____ /_____ /_____ WHAT TRIGGERS MY ASTHMA _____

Baseline Severity

Best Peak Flow

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

GREEN ZONE — DOING WELL — GO!

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

Peak Flow is between: _____ **and** _____

80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH

YELLOW ZONE — GETTING WORSE — CAUTION

You have ANY of these:

- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

Peak Flow is between: _____ **and** _____

50-79% of personal best

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ *puffs or 1 nebulizer treatment of* _____

Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine _____ **and** call your health care provider today.

Step 3: If you are in the **YELLOW ZONE** **more than 6 hours**, or your symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE — EMERGENCY — GET HELP NOW!

You have ANY of these:

- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: _____ **and** _____

Below 50% of personal best

Step 1: Take your quick-relief medicine **NOW:**

MEDICINE	HOW MUCH

or 1 nebulizer treatment of _____

AND

Step 2: Call your health care provider **NOW**

AND

Go to the emergency room **OR** CALL **911** immediately.

_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: _____ /_____ /_____ MD/NP/PA SIGNATURE _____

This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.
My child *(circle one)* **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse *(if applicable)*.

DATE: _____ /_____ /_____ PARENT/ GUARDIAN SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____

Asheville Christian Academy

Contract for Self-Carried Medication

Student: _____ Grade: _____

Parent Signature: _____ Phone No._____

Medication: _____ Dose and Time: _____

Medication may be carried by students who are 6th grade and older who have diagnosed life threatening allergies, students with asthma, students with diabetes, and students with chronic conditions which have been discussed with school nurse.

Both student's health care provider and parent/guardian must sign off in approval of student carrying their medication.

Health Care Provider Signature: _____ Phone No._____

*The student's name must appear on the medication and/or inhaler device.

Student Responsibilities:

I plan to keep my diabetes medication/equipment, Epinephrine Auto-injector, or inhaler/equipment with me at school;

I agree to use my diabetes medication/equipment, Epinephrine Auto-injector/equipment, inhaler/equipment, or prescribed medication for chronic condition in a responsible manner, in accordance with my licensed health care provider's orders;

I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition, and I will not allow any other person to use my medication or equipment.

Student Signature: _____ Date: _____

Nurse Checklist:

____ Emergency Action Plan complete and on file at school

____ Demonstrates correct use/administration

____ Verbalizes proper and prescribed timing for medication

____ Agrees to carry medication or keep in established location

____ Knows health condition well

____ Keeps a second labeled container in health office

____ Will not share medication or equipment with others

Comments: _____

School Nurse Signature:_____ Date: _____

*Form may be faxed to School Nurse, Kristin Moyers RN. 828.581.2218