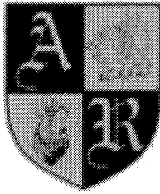

American Renaissance School

"A Downtown Community School"

Request for Medication Administration in School

To be completed by physician

Name of Student: ____
School: ____

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

Dosage and Route: ____

Time(s) medication is to be given: a.m. _________ p.m. _______PRN: __________
To be given from: (date) ______________ to/through: _______________________

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.)
____

Contraindications to administration:____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office__________________
b. Telephone ______________________________
Take child immediately to the emergency room at ________________________

FOR SELF-ADMINISTRATION –
☐ **Student has demonstrated ability and understands the use of and may carry and self- administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.**

Asthma/allergic reaction __MDI (*Metered Dose inhaler) __MDI with spacer * Diabetes __ insulin __ glucose __Epinephrine

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.
A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2 The student also must have a self-medication agreement on file.

Date _____________ Physician's Signature________________________________

(Over)

Elementary: 111 Cooper Street • Statesville, NC 28677 • 704-924-8870 • Fax 704-873-1398
Middle: 217 S. Center Street • Statesville, NC 28677 • 704-878-6009 • Fax 704-878-9350
Website: www.arsnc.org

PARENT'S PERMISSION

I hereby give my 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 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 all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken) and replace the medication when it expires.

Parent or Guardian's Signature: ____

Telephone Number ____________________ Date: __________________

(School Use Only)

Name and title of person to administer medication (unless self-administered)________________________________

Approved by____ ____________________

Principal's Signature Date

Reviewed by____ ____________________

School Nurse's Signature Date

SCHOOL ASTHMA RECORD

NAME OF STUDENT ______________________________ SCHOOL _______________

GRADE ____ YEAR ________________

PARENT/GUARDIAN #1____________________________ PHONE _______________

PARENT/GUARDIAN #2____________________________ PHONE _______________

HEALTH CARE PROVIDER ___________________________ PHONE _______________

1. Briefly describe what causes the child's asthma symptoms (weather, cold, allergies, exercise):
2. How often does the child have a bad enough asthma attack that he/she needs to see a health care provider or go to the hospital?
3. Name any medication that the child takes for his/her asthma attack (how often and how much):
   at home ____
   at school ____
4. Does your child suffer any side effects from these medications? Please list them:
5. Name any activities/exercise in which your child CANNOT participate:
6. What does your child do at home to relieve wheezing during an asthma attack? Please check all that apply.
   ___Breathing exercises   Takes medicine: ___ Inhaler
   ___ Rest/relaxation   ___ Nebulizer
   ___ Drinks liquids   ___ Oral medicine
7. Do you know what your child's baseline peak flow rate is?
   ___ No ___ Yes What is it? _______________________________________
8. How do you want the school to treat an asthma attack if it should happen?

PLEASE READ THE EMERGENCY ACTION PLAN FOR ASTHMA ON THE REVERSE SIDE AND ADD ANY FURTHER INSTRUCTIONS THAT YOU WISH FOR YOUR CHILD.

STUDENT NAME ____

EMERGENCY ACTION PLAN

ASTHMA

SYMPTOMS: Difficulty breathing with short inhalations and longer exhalations, rapid, shallow breathing, wheezing (high-pitched noise heard with breathing), excessive coughing (may cause vomiting), sensation of chest tightness, flaring of nostrils, tingling/numbness in fingers/toes, loss of color in lips.

INTERVENTIONS:

1. Attempt to calm student. Stay with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Have student take prescribed medication as ordered by hearth care provider and parent.
5. Notify school nurse if in building.
6. Notify parent of severe breathing difficulty or if medication is not effective in 15 minutes.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to ____________________________ Hospital.
8. Additional instructions:

PARENT/GUARDIAN SIGNATURE ______________________ DATE __________

SCHOOL NURSE__________________________________ DATE __________

PLEASE NOTE: If medication or inhaler are to be taken at school, a medication authorization form must be completed by parent and physician and kept at the school. This form is to be completed each year.

This information will be shared with your child's teacher unless you state otherwise.

School Nurse Health Information and Emergency Contact (Must be completed annually)

Student's Name:________________________________ Date of Birth:____________ Teacher/Grade:____________________

Before/After school: yes/no Parent/Guardians: ____

Emergency Numbers: *(List in the order to be called)*

Name	Relationship	Daytime #

Physician________________________ Office Phone ____________________ Hospital Preference:________________

Insurance Company:____________________ Policy Number:____________________

Head injury/Concussion within the past year: ☐ yes ☐ no

If yes, Date and description of injury: ____

Drug Allergy(s): ☐ None known ☐ Yes (list) ____

Asthma Triggers: ☐ environmental ☐ seasonal ☐ exercise induced Inhaler at school-☐ yes ☐ no

MD order required Inhaler location: ☐ Carried by student (must be on MD order) ☐ Classroom ☐ Nurse's office

Diabetes ☐ Type I ☐ Type II Diagnosis Date: ______________ Insulin by: ☐ Pump ☐ Injections

Diabetes Care Plan: ☐ yes ☐ independent with all care Glucagon:☐ yes ☐ no

Please call for Nurse Conference- Notify your school nurse and principal immediately if newly diagnosed

Food Allergy: ☐ Peanuts ☐ Tree nuts ☐ Milk ☐ Other ____

Date/Type of Last Reaction: ____

Student Needs during school day: ____

Diet/Medication Orders signed by MD required

Severe Sting Allergy:

Date/Type of Last Reaction: ____

****Notify your school nurse and principal immediately if anaphylaxis may occur****

Seizures:

☐ controlled with medication ☐ medication needed at school ☐ no medication needed at school

Date and type/description of last seizure: ____

Other conditions or information to help us better serve your child: ______________________________

____

Does your child take routine medication(s) ☐ yes ☐ no List meds: ______________________________

Does your child need medication(s) at school? ☐ yes ☐ no List meds: ______________________________

If your child needs medication (prescription or over the counter) during the school day, a medication consent form is required to be signed by the health care provider and the parent/guardian. **Medication cannot be given at school until appropriate consents have been received.

I authorize all emergency transportation, medical and surgical treatment, X-ray, laboratory, anesthesia, and/or medical or hospital procedures as may be performed or prescribed by the attending physician and/or paramedic for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent/Guardian: ________________________________ Date: ____________________

A health care provider's written diagnosis is required in order for an Individualized Healthcare Plan to be developed by the school nurse. Also, please let your school nurse know if your child participates in extracurricular school activities.