Medications at school

A MEDICATION REQUEST FORM must be filled out and signed by physician **AND** parent/guardian, for any medications to be given or taken at school. *Please see attached forms.*

School Staff/Nurse may not give **ANY** type of medication without a completed medication form. *This includes prescription and nonprescription medications such as Tylenol, Motrin, Tums, cough drops, Benadryl, antibiotic ointments, cough medicine, chap stick/lip balm, etc.*

Parent must provide medication.

Medication must be brought to school in original labeled container.

Parent must check in all medications with the school nurse.

New medication forms should be provided at the beginning of each school year.

Parent is responsible for picking up any leftover medications at the end of the school year.

Medical Issues/Allergies

Please contact the School Nurse if your child has any of the following:

Allergies requiring EpiPen or Benadryl	*Seizures*
Asthma	*Sickle Cell Disease*
Diabetes	*Special Diet*
Hearing Problems	*Vision Problems*
Bleeding Disorder	*Special Needs*
Gastrointestinal Problems	*Heart Problems*
Kidney Problems	*Migraine Headaches*
Bone Problem	*Other conditions or concerns*

AMERICAN RENAISSANCE SCHOOL

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

To be completed by physician

Name of Student: _____

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

Dosage and Route: _____

Time(s) medication is to be administered: 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: _____

C. Take child immediately to the emergency room at (hospital) _____

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* ___ Epinephrine ___
Diabetes ___ insulin ___ glucose

*Parents/guardians 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 the requirements stated in G.S. 115C-375.2. The student also must have a self-medication agreement on file.

Physician's Signature _____ Date _____

Continued on other side

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

PARENT'S PERMISSION

I hereby give my permission for my child, _____, 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 Signature Date

Printed by Kathy Shipman

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 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
   ___ Rest/relaxation
   ___ Drinks liquids
   Takes medicine: ___ Inhaler
   ___ Nebulizer
   ___ 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.

PUBLIC SCHOOLS OF NORTH CAROLINA
DEPARTMENT OF PUBLIC INSTRUCTION | Catherine Truitt, *Superintendent of Public Instruction*
WWW.DPI.NC.GOV

Occupational Survey

Student Name : _____
Last Name **First Name**

School: _____ **Grade:** _____

The Migrant Education Program, through the North Carolina Department of Public Instruction, provides support and instructional services to children and families who have moved in the past three years and who have done agriculture or fishing work. We appreciate your help in determining if your children or relatives qualify to receive services in this program. Please answer the following questions and return the survey to the school.

1. **Have you or someone in your family worked in any of the following areas below in the last three years?**
   No_____ **Yes** _____ **(Select all that apply and continue to question number 2)**

2. **Have you or your family moved to another school district or to another city or county in the last three years?**
   No_____ **Yes**_____

Work in the harvest of fruits and vegetables, tobacco, sweet potatoes, nuts, cotton, or in agricultural farms, ranches, fields, and vineyards ☐	Working in a fruit or vegetable cannery or in a fruit or vegetable packing plant ☐	Working in a dairy ☐	Working in a fishery or on a shrimp or catfish farm ☐
Working in a slaughter house (chicken, cow, or pig) ☐	Working on a poultry or hog farm ☐	Working in a plant nursery or orchard; growing or harvesting trees ☐	Other similar work in agriculture, please explain: _____ _____ _____

3. **How long ago did you arrive to this school district?** **Month** _____ **Year** _____
4. **Parent(s)' Name(s)** _____
5. **What is your current address?**

   _____
   Address

   _____
   City **State** **Zip Code**

6. **Phone Number(s):** _____

FEDERAL PROGRAM MONITORING & SUPPORT DIVISION
6351 Mail Service Center, Raleigh, North Carolina 27699-6351 | 984) 236-2786 | Fax (984) 236-2099
AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Printed by Kathy Shipman

PUBLIC SCHOOLS OF NORTH CAROLINA

DEPARTMENT OF PUBLIC INSTRUCTION | Mark Johnson, *Superintendent of Public Instruction*

WWW.NCPUBLICSCHOOLS.ORG

Encuesta Ocupacional

Nombre del Estudiante: _____
Apellido **Primer Nombre**

Escuela: _____ **Grado:** _____

El Programa de Educación para estudiantes migrantes a través del Departamento de Instrucción Publica del Estado provee servicios de apoyo a los niños y familias que se han mudado en los últimos 3 años y que han trabajado en agricultura o pesca. Agradecemos que nos ayuden a determinar si su niño o pariente califica para recibir servicios en este programa. Por favor, conteste las siguientes preguntas y entréguelas a la escuela.

1. **¿Usted o alguien en su familia ha trabajado en alguno de los siguientes trabajos abajo en los últimos tres años?**
   - ☐ **NO**
   - ☐ **Sí (Seleccione todo que aplica abajo y favor de continuar a la Pregunta #2)**

2. **¿Usted o su familia se ha mudado a otra zona escolar, o a una ciudad o condado en los últimos tres años?**
   - ☐ **No**
   - ☐ **Sí**

 Trabajando en los campos de agricultura cosechando frutas, verduras, nueces, melones, algodón, o en el silaje de zacate, paja, etc ☐	 Trabajando en el enlatado de frutas o verduras o en una planta empacadora ☐	 Trabajando en la lecherías ☐	 Trabajando en la pesca, granjas de camarón o peces ☐

 Trabajando en el corte de carnes crudas (pollos, reses, puercos) ☐	 Trabajando en granjas avícolas ☐	 Trabajando en huertas, viveros, talando árboles o limpiando la tierra) ☐	 Otro trabajo similar, favor de explicar: Como cercando ranchos, fincas o huertas _____ _____ _____

3. **¿Hace cuánto tiempo se mudó a este condado?** **Mes** _____ **Año** _____
4. **Nombre de uno de los padres** _____
5. **¿Cuál es su dirección actual?**

   _____
   Dirección

   _____
   Ciudad **Estado** **Codigo Postal**

6. **Teléfono:** _____

FEDERAL PROGRAM MONITORING & SUPPORT DIVISION

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