

ADMINISTRATION OF MEDICATION AT SCHOOL

School Year 2017-2018

Royal Redeemer Lutheran School
11680 Royalton Road
North Royalton, Ohio 44133
440.237.7988
Fax 440.237.7713

In accordance with 3313.73, 3313.76 Ohio Revised Code.

School policy requires consent of the parent/legal guardian and a written statement (order) from the licensed prescriber before school personnel can give any medication to a student. The following information is necessary in order to comply with this policy.

ALL REQUESTED INFORMATION MUST BE COMPLETED IN FULL.

Please return the completed form to the school office.

STUDENT \_\_\_\_\_ DOB \_\_\_\_\_ GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER

The above mentioned student is under my care for (diagnosis): \_\_\_\_\_

Medication, Dosage, and Route \_\_\_\_\_

At the following times \_\_\_\_\_

Starting date: \_\_\_\_\_ Expiration date of this request: End of school year \_\_\_\_\_ Other date \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

IF PRESCRIBING AN ASTHMA INHALER OR EPI PEN

\*Authorization for Student to Carry Inhaler OR Epi Pen: \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Prescriber has determined that the student is capable of possessing and using appropriately: \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Prescriber has trained the student in the proper use: \_\_\_\_\_ YES \_\_\_\_\_ No

\*Any adverse reactions to student or unauthorized user that should be reported to the physician:

\*Procedure to follow in the event that inhaler or Epi pen does not produce relief

\*If the student is to possess an Epi pen for self injection, a SECOND back up pen MUST be in the possession of the school staff.

\*These are requirements as of March 1, 2007 as per ORC Sec. 3313.718.

Licensed Prescriber \_\_\_\_\_ Printed name \_\_\_\_\_ Address \_\_\_\_\_

Licensed Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number Emergency Number \_\_\_\_\_

MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE AFFIXED LABEL FROM THE PHARMACY. THE LABEL MUST SHOW THE STUDENT'S NAME, NAME OF THE MEDICATION, THE DOSAGE DIRECTIONS, THE LICENSED PRESCRIBER'S NAME AND THE RX NUMBER (IF THERE IS ONE.)

TO BE COMPLETED BY THE PARENT/GUARDIAN

I give my permission for the principal or his/her designee to administer the medication as prescribed above to my child and further agree to the following:

- 1. Submit to school personnel a revised statement signed by the licensed prescriber of the above medication when any change in the original statement (order) occurs.
2. Submit to school personnel a written statement when medication, given on a daily or as needed basis, has been discontinued.
3. Grant permission for the school to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child with medication administration instructions.
5. Provide safe transportation of the medication to and from school.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent Emergency Day Phone Number \_\_\_\_\_

**Royal Redeemer Lutheran School Food Allergy Action Plan**

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

Place  
Child's Picture  
Here

ALLERGY TO: \_\_\_\_\_

**Asthmatic** Yes\*  No  \*Higher risk for severe reaction

**⊛ STEP 1: TREATMENT**

**Symptoms:**

- If a food allergen has been ingested, 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\*\*** Thready pulse, low blood pressure, fainting, pale, blueness
- **Other\*\*** \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give  
The severity of symptoms can quickly change. **\*\*Potentially life-threatening.**

**Give Checked Medication:**

|                 |                   |
|-----------------|-------------------|
| ___ Epinephrine | ___ Antihistamine |
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(Options to be determined by physician authorizing treatment)

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) **EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg Auvi-Q™**  
(see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_ medication/dose/route

**Other:** give \_\_\_\_\_ medication/dose/route

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

**⊛ STEP 2: EMERGENCY CALLS**

1. Call 911 (or Rescue Squad: \_\_\_\_\_) State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ at \_\_\_\_\_
3. Parents \_\_\_\_\_ Phone Number(s) \_\_\_\_\_ or \_\_\_\_\_
4. Emergency Contacts:  
Name & Relationship  
A. \_\_\_\_\_ Phone Number(s) \_\_\_\_\_ or \_\_\_\_\_  
B. \_\_\_\_\_ Phone Number(s) \_\_\_\_\_ or \_\_\_\_\_

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

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

(Required)