ADMINISTRATION OF MEDICATION AT SCHOOL

School Year 2024-2025

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
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine
___Epinephrine	___Antihistamine

(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:_____) may be needed. **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)