Morrice Area Schools

Authorization for Administration of Medication at School

Dear Parent & Student,

New Medication Orders are required every school year. Our goal is your child's safety—the right medication, to the right child, in the right amount, at the right time. Your help is needed to achieve this goal!

Please complete the following checklist for Medications to be Administered at school:

Medication Checklist	**Requirements for Medication Administration at School**
	Parent completed Medication Authorization Form
	Physician completed Medication Authorization form
	Medication in original container
	Prescription Medication labeled with Name of Student, Name of Medication, Time of Administration, Dosage, Route of Administration, Expiration Date
	Non-Prescription medication in unopened original container with expiration date
	Parent/Guardian brings medication to school office
	All forms complete and turned in to the school office

- The very first time a student takes a new medication the first dose should be given at home
- Each Medication needs it own authorization
- Refill of the medication is the responsibility of the parent/guardian
- Expired medication will not be administered
- Unused medication will be discarded unless picked up by the parent/guardian on or before the last day of school
- Action plans for Diabetes, Severe Asthma, Seizures, and allergies must be completed every school year
- Additional forms can be found on the Morrice Area Schools website
- Food Allergies: Food services menu options are all nut free. Please contact Food Services for alternative options for dairy allergies, gluten allergies, etc. A physician note may be required.

Permission Form for Prescribed Medication and All Over-the-Counter Medication
(Including Ointments and Creams)

School: _____

***Prescription medication must be in a container labeled by the pharmacists or prescriber.**
***Non-prescription medication must be in the original sealed/new container with the label intact.**
***An adult must bring the medication to the school.**

Morrice Area Schools

Date form received by the school: _____

Student: _____ Date of Birth or Age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician for prescription medication or parent/guardian for over the counter medication.

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of Medication: _____ If PRN(as needed), frequency: _____

Reason for medication: _____

Relevant side Effects: ☐None expected ☐ Specify: _____

Form of medication/treatment: ☐Capsule/tablets ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other: _____

Prescribers Name/Title: _____ Telephone number: _____

Prescribers Signature: _____ Office Address: _____

_____

Start: Δ date form received Other dates: _____

Stop: Δ end of school year Other date/duration: _____

Δ For episodic/emergency events only

Special storage requirements: Δ None Δ Refrigerate Other: _____

This student is both capable and responsible for self-administering this medication; Asthma inhalers, Epi-pen, or prescribed Emergency Medication.

Δ No Δ Yes-Supervised Δ Yes-Unsupervised

This student may carry this medication: Δ No Δ Yes

Please indicate if you have provided additional information:

Δ On the back side of this form Δ As an attachment

Date: _____ School Admin Signature of Approval: _____

To be completed by parent/guardian

I request that _____ receive the above medication at school according to standard school policy.
Name of child

I request that _____ be allowed to self-administer the above medication at school according to the school policy.
Name of child

Date: _____ Signature: _____ Relationship: _____

Permission Form for Prescribed Medication and All Over-the-Counter Medication (including Ointments and Creams)

RELEASE OF LIABILITY / WAIVER

I acknowledge that the information and instructions provided (**on page 1 of the Medication Permission Form**) for dispensing prescribed and non-prescribed medication to my minor child or ward, _____ (**print first and last name of minor child**) is accurate. I recognize and acknowledge that there are certain risks of physical injury in connection with administering prescribed and non-prescribed medication(s) to my minor child or ward. In consideration of the District administering medication to my minor child or ward, I fully release or discharge the District, its' officers, agents, volunteers and employees from any and all claims from injuries, damages and losses that I, my minor child or ward may have arising out of, connected with, incidental to, or in any way associated with the administering of prescribed or non-prescribed medication. I further agree to indemnify and hold harmless, the District, its' officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by my minor child or ward arising out of, connected with, incidental to or in any way associated with the administering of prescribed or non-prescribed medication. I understand that it is my responsibility to inform the District if any changes in the dispensing of prescribed or non-prescribed medication changes. If such change occurs, I will complete an updated medication form that reflects those changes.

By signing this Release of Liability / Waiver Form, I represent that I am the Parent / Legal Guardian of _____, who is under eighteen (18) years of age. I represent that I've read the above referenced Release of Liability / Waiver provision and am fully familiar with the contents thereof.

To be completed by Parent/Legal Guardian

_____ _____ _____

Signature of Parent or Legal Guardian | Relationship

_____ _____

Print Name of Parent or Legal Guardian | Date

Epi Location: _____

Allergy Action Plan

To be completed by parents and healthcare team and reviewed by school staff every school year

Student Information

Student Name: _____ Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

ALLERGY TO: _____

Asthmatic: ▢ Yes (high risk for severe reaction) ▢ No

Additional Health problems besides Anaphylaxis: _____

Concurrent Medications: _____

Recognize Symptoms: Only a few may be present. Severity can change quickly. Act Fast!

Treatment to be determined by physician:

Symptoms		Antihistamine	Epi
Mouth	Itchy, tingling, swelling of lips and/or tongue		
Skin	Hives, itching, redness, swelling		
Gut	Vomiting, diarrhea, abdominal cramps		
Throat*	Itching, tightness, hoarseness		
Lung*	Cough, Wheeze, shortness of breath		
Heart*	Weak pulse, dizziness, passing out		
Other:			

*Some symptoms can be life threatening. *Inhaler or antihistamine cannot be depended on during anaphylaxis.

Emergency Anaphylaxis Action Steps

1. Locate Epi: _____ Dose: _____
2. Inject Epinephrine in thigh
3. Call 911 - state that an allergic reaction has been treated and additional Epi may be needed
4. Call Emergency Contact

   Emergency Contact #1: _____ Phone: _____

   Emergency Contact #2: _____ Phone: _____

   Emergency Contact #3: _____ Phone: _____

Comments: _____

Signatures

Physician: _____ Date: _____

Parent/Guardian: _____ Date: _____

Office Use:
Form Received: _____ Medication form received: _____

Date: _____

Dietary Restriction Plan

Complete this form to request dietary accommodations due to **medical condition or allergy only.**
To be completed by the parent/guardian and healthcare team.

Student Information

Student Name: _____ Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

Dietary Restriction

ALLERGY TO: _____

Response to allergen: _____

Disability/Medical Condition: _____

☐ Major Life Activity Affected: _____

☐ Texture/Other Adaptive Equipment Needed: _____

Foods to be Omitted: _____ _____

_____ _____

_____ _____

Diet Prescription and substitutions: _____

_____

_____

Does Student plan on eating school breakfast and/or school lunch? ☐ Yes ☐ No ☐ Maybe

Signatures

Physician: _____ Date: _____

Parent/Guardian: _____ Date: _____

Parent/Guardian Phone #: _____

Contact Dining Service Director with Questions: Janet Killingsworth at killingsworthj2@perry.k12.mi.us

Return completed form to the office.

Office Use:
Form Received: _____ Medication form received: _____

Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/Health Care Provider _____ Phone numbers _____
- Physician Signature _____ Date _____

Severity Classification

- ❍ Mild Intermittent ❍ Moderate Persistent
- ❍ Mild Persistent ❍ Severe Persistent

Triggers

- ❍ Colds ❍ Smoke ❍ Weather
- ❍ Exercise ❍ Dust ❍ Air pollution
- ❍ Animals ❍ Food
- ❍ Other _____

Exercise

1. Pre-medication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

Medicine	How Much to Take	When To Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Peak Flow Meter

Between 50 to 80% of personal best or _____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days
- ❍ Change your long-term control medicines by _____
- ❍ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ❍ Take quick-relief treatment again
- ❍ Change your long-term control medicines by _____
- ❍ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Peak Flow Meter

Between 0 to 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if

- ❍ Still in the red zone after 15 minutes
- ❍ If you have not been able to reach your physician/health care provider for help
- ❍ _____

Call an ambulance immediately if the following danger signs are present

- ❍ Trouble walking/talking due to shortness of breath
- ❍ Lips or fingernails are blue

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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