Parent Request and Physicians' Order Form for Medication

Student Name:_____ DOB:_____School Year:_____

Diagnosis	Name of Medication	Dosage	How to give	Time(s) to give
ADHD				
Cystic Fibrosis				
Seizure				
Other				

Physician Printed Name:_____ Telephone:_____

Physician Signature:_____ Date:_____

To be completed by parent:

I understand that:

- Non-medical personnel conduct the medication administration.
- It is my responsibility to deliver the medication to school.
- If my child participates in Raleigh Charter High School before/after- school activities/sports, I will assume responsibility for notifying the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity.

I request that:

- My child be administered the medication as indicated in the physician's order.

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 Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Print Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date:_____

2019-2020 SEVERE ALLERGY ACTION PLAN

MUST BE COMPLETED AND SIGNED BY A LICENSED ALLERGIST IF YOUR CHILD REQUIRES EPINEPHRINE

List ANY ALLERGY (to food, medicine, or other) that may prompt a life-threatening allergic response.

Allergen	**Severe Reaction Caused When:**	**Required Response** ❏ **Staff will administer** ❏ **Student will self-administer epinephrine per physician care plan**	**Has severe reaction ever occured?**	**Dosage & Additional Instructions**
	❏ Allergen is ingested ❏ Allergen touches skin ❏ Allergen is in area (airborne allergy)	❏ Immediately after known exposure to allergen, even if no symptoms are noted ❏ At first sign of any symptom ❏ With signs or symptoms of anaphylaxis	❏ Yes Dates:_______ ❏ No	❏ 0.15 mg ❏ 0.3 mg ❏ If provided , repeat dose after ___ minutes for continued symptoms
	❏ Allergen is ingested ❏ Allergen touches skin ❏ Allergen is in area (airborne allergy)	❏ Immediately after known exposure to allergen, even if no symptoms are noted ❏ At first sign of any symptom ❏ With signs or symptoms of anaphylaxis	❏ Yes Dates:_______ ❏ No	❏ 0.15 mg ❏ 0.3 mg ❏ If provided , repeat dose after ___ minutes for continued symptoms
	❏ Allergen is ingested ❏ Allergen touches skin ❏ Allergen is in area (airborne allergy)	❏ Immediately after known exposure to allergen, even if no symptoms are noted ❏ At first sign of any symptom ❏ With signs or symptoms of anaphylaxis	❏ Yes Dates:_______ ❏ No	❏ 0.15 mg ❏ 0.3 mg ❏ If provided , repeat dose after ___ minutes for continued symptoms
	❏ Allergen is ingested ❏ Allergen touches skin ❏ Allergen is in area (airborne allergy)	❏ Immediately after known exposure to allergen, even if no symptoms are noted ❏ At first sign of any symptom ❏ With signs or symptoms of anaphylaxis	❏ Yes Dates:_______ ❏ No	❏ 0.15 mg ❏ 0.3 mg ❏ If provided , repeat dose after ___ minutes for continued symptoms

Other Non-Life Threatening Allergies & Recommended Treatment:	

Note to Allergist/MD or Parent: If you do not feel this form adequately addresses your patient's allergy(ies) please feel free to submit additional documentation.

Allergist's /MD's Name:____ Phone:___________________________

Allergist's/ MD's Signature:____ Date:_____________________________

Authorization for Student to Carry and Independently Self-Administer Emergency Medication

Student Name:_____

To be completed by PHYSICIAN:

The student must have the medication(s) listed on the reverse of this form during the school day or at school-sponsored events. The student has been instructed in the treatment plan, self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer the medications for asthma and/or anaphylaxis. **Adult supervision is not required.** The student has been instructed in the treatment plan, self-administration for the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

[ ] Asthma [ ] Allergy [ ] Other:_____

Printed Physician's Name:_____

Physician's Signature:_____Date:_____

To be completed by PARENT:

I request and give permission for my child to carry and self-administer the medication listed on the reverse of this form during the school day, at school-sponsored activities or while in transit or or from school. I have observed my child demonstrate the necessary skill to implement the care plan prescribed by his/her health care provider. Adult supervision will not be required.

I understand that:

- If required by the care plan, I am obligated to and will provide the school back-up medication (in addition to what student will carry) to be kept at school.
- If my child participates in Raleigh Charter High School before/after-school activities/sports, I will assume responsibility for notifying the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity.
- My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

For Epi-Pen only:

[ ] In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, I specifically authorize a trained school staff member to administer the Epi-Pen and call 911.

Parent/Guardian Signature:_____Date:_____

To be completed by STUDENT:

- I plan to keep my medication and equipment with me at school
- I will use only as prescribed by my doctor.
- I will not allow any other person to use my medication.
- I will notify a school staff member if I self-administer my medication, or if I am having more difficulty than usual with my health condition.

Student Signature:_____Date:_____

Glucagon Authorization Form

Name of Student:_____ Date of Birth:_____

Parental/Guardian Responsibilities:

- The parent or guardian is to furnish the glucagon medication to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- If the glucagon medication is administered to the student, the parent or guardian will immediately replenish the school supply.
- If a student has a change in his/her prescription, the parent or guardian is responsible for promptly providing the updated prescription and dosing information as described above to the school.

In the event my child is experiencing severe hypoglycemic reaction (loss of consciousness, seizure), I specifically authorize a school staff member to administer the glucagon prescribed by the physician and to call 911. I also give permission for school personnel to release personal or medical information about my child in a health-related emergency situation to emergency personnel if necessary. I understand this form authorizes designated school personnel to administer glucagon and disclose healthcare information in emergency situations.

Parent/Guardian Name:_____

Parent/Guardian
Signature:_____Date:_____

Diabetes Medication Form

Student Name:_____ Date:_____

To be completed by PHYSICIAN:

The above named student is under my care. I feel it is medically appropriate for the student to self-administer diabetes medication and be in possession of diabetes medication and supplies at all times. The medication prescribed for this student is:

Name of Medication:_____

Dosage:_____

Printed Physician's Name:_____

Physician's Signature:_____Date:_____

_____

To be completed by PARENT:

I authorize my child _____ to carry and self-administer prescribed diabetes medication and supplies.

Parent/Guardian
Signature:_____Date:_____

_____

To be completed by STUDENT:

- I plan to keep my medication and equipment with me at school
- I will use only as prescribed by my doctor.
- I will not allow any other person to use my medication.
- I will notify a school staff member if I self-administer my medication, or if I am having more difficulty than usual with my health condition.

Student Signature:_____Date:_____

Raleigh Charter High School
Plan of Treatment for Asthma

Name of Student:_____DOB:_____ School Year:_____

Diagnosis	Name of Medication	Dosage	How to give	Time(s) to Give
Exercise-Induced Asthma	❑ Albuterol ❑ Xopenex	**Check One** ❑ 2 Puffs ❑ 1 Vial (ampule)	❑ Inhaler with spacer, if provided ❑ Nebulizer	Before exercise as needed to prevent symptoms
Asthma Yellow Zone	❑ Albuterol ❑ Xopenex	**Check One** ❑ 2 puffs ❑ 4 puffs ❑ 1 Vial (ampule)	❑ Inhaler with spacer, if provided ❑ Nebulizer	❑ Every 4 hours as needed to relieve symptoms ❑ _____
Asthma Red Zone	❑ Albuterol ❑ Xopenex	**Call 911** ❑ 4 puffs ❑ 1 Vial (ampule)	❑ Inhaler with spacer, if provided ❑ Nebulizer	**For Emergency Symptoms**

1. Student must notify school personnel if medication is self-administered, and if significant symptoms of wheezing, severe cough, or shortness of breath persist after the listed medication is administered. Upon notification, school personnel should notify the student's family immediately.
2. If symptoms resolve, school personnel will notify parent and monitor for recurrence of symptoms. Any student requiring bronchodilator medication for a recurrence (second episode) of symptoms during the same day will be sent home for the rest of the school day.
3. Additional care recommended by child's physician as listed below:

   _____

   _____

   _____

   _____

Medications are kept in the front office (unless student is specifically authorized to self-administer asthma medication by physician-- please see "Authorization for Student to Carry and Self-Administer Emergency Medication" form on the reverse side of this form).

PHYSICIAN SIGNATURE:_____ DATE_____

Authorization for Student to Carry and Independently Self-Administer Emergency Medication

Student Name:_____

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[ ] Asthma [ ] Allergy [ ] Other:_____

Printed Physician's Name:_____

Physician's Signature:_____Date:_____

_____

To be completed by PARENT:

I request and give permission for my child to carry and self-administer the medication listed on the reverse of this form during the school day, at school-sponsored activities or while in transit or or from school. I have observed my child demonstrate the necessary skill to implement the care plan prescribed by his/her health care provider. Adult supervision will not be required.

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Parent/Guardian Signature:_____Date:_____

_____

To be completed by STUDENT:

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- I will notify a school staff member if I self-administer my medication, or if I am having more difficulty than usual with my health condition.

Student Signature:_____Date:_____