Medication Authorization Form School Year: 2022 – 2023

*Parent/guardian AND a licensed healthcare professional **must** provide written permission for school personnel to administer medication(s) every school year.*

PHYSICIAN/LICENSED PROVIDER – PLEASE COMPLETE

MEDICATIONS REQUIRED DURING SCHOOL HOURS Authorizations expire at the end of the school year or following Extended Year Summer (ESY) session.						
Diagnosis/Reason for Medication	ICD10 Code	Medication Name	Dose	Time	Route	Possible Side Effects

INHALER – Please include Asthma Action Plan:

☐ Student may carry/self-administer inhaler according to the licensed prescriber's instructions. This student has been instructed on the proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student <u>should not carry</u> inhaled medication.

EPINEPHRINE AUTO-INJECTOR – Please include Anaphylaxis Action Plan:

☐ Student may carry/self-administer epinephrine auto-injector (EpiPen®) according to the licensed prescriber's instructions. This student has been instructed on the proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student <u>should not carry</u> epinephrine auto-injector (EpiPen®) medication.

OTHER – Please include Emergency Action Plan:

☐ Student may carry/self-administer ____ (please identify) according to the licensed prescriber's instructions. This student has been instructed on the proper use, side effects, and safeguards regarding this medication.

______________________________ Signature of Licensed Healthcare Provider

______________________________ Printed Name of License Healthcare Provider

______________ Date

______________________________ Clinic Name and Address

______________ Clinic Phone #

______________ Clinic Fax #

PARENT/GUARDIAN MEDICATION AUTHORIZATION

1. I request the medication listed above be given during school hours as ordered by this student's licensed healthcare provider. Only daily medications and those for life-threatening/emergency conditions will be sent on field trips.
2. I will provide the school with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s) (e.g. dosage change, time change, discontinued, etc…).
3. I give permission to designated school staff to administer the above medication(s) and/or to perform treatment(s). I release the school and its personnel from any liability in the administration of this medication(s) and/or treatment(s).
4. I understand that school staff cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from both the student's physician/licensed prescriber and parent/guardian.
5. I give permission for Health Office staff to consult with this student's licensed healthcare provider regarding questions about the above medical condition(s) and medication(s)/treatment(s)/procedure(s) being used to treat the condition.
6. I give permission for Health Office staff to communicate, as needed, with school staff about this student's health condition(s) and the action of the medication(s)/treatment(s)/procedure(s).

Parent/Guardian Signature: ________________________________ Date: ______________

Printed Name of Parent/Guardian: ________________________________ Phone: ______________

Asthma Action Plan

DATE: ______ /______ /______

PATIENT NAME ______________________________

WEIGHT: ______________

PARENT/GUARDIAN NAME ______________________________ PHONE ______________

HEIGHT: ______________

PRIMARY CARE PROVIDER/CLINIC NAME ______________________________ PHONE ______________

DOB: ______ /______ /______

WHAT TRIGGERS MY ASTHMA ______________________________

Baseline Severity

Best Peak Flow

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

GREEN ZONE — DOING WELL — GO!

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

Peak Flow is between: ______ **and** ______

80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH

YELLOW ZONE — GETTING WORSE — CAUTION

You have ANY of these:

- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

Peak Flow is between: ______ **and** ______

50-79% of personal best

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

______________ *puffs or 1 nebulizer treatment of* ______________

Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine ______________ **and** call your health care provider today.

Step 3: If you are in the **YELLOW ZONE more than 6 hours**, or your symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE — EMERGENCY — GET HELP NOW!

You have ANY of these:

- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: ______ **and** ______

Below 50% of personal best

Step 1: Take your quick-relief medicine **NOW:**

MEDICINE	HOW MUCH

or 1 nebulizer treatment of ______________

AND

Step 2: Call your health care provider **NOW**

AND

Go to the emergency room **OR** CALL **911** immediately.

______ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

______ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: ______ /______ /______ MD/NP/PA SIGNATURE ______________________________

This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.
My child *(circle one)* **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse *(if applicable)*.

DATE: ______ /______ /______ PARENT/ GUARDIAN SIGNATURE ______________________________

FOLLOW-UP APPOINTMENT IN ______________ AT ______________ PHONE ______________

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FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________________ D.O.B.: ____________

Allergic to: ______________________________

Weight: __________ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens:______________________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________

Antihistamine Dose: ______________

Other (e.g., inhaler-bronchodilator if wheezing): ______________

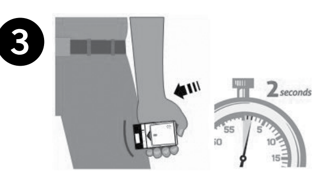
____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

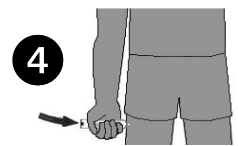
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it ‘clicks’. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA’S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the “twist arrow” to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it ‘clicks’. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: ____________

PARENT/GUARDIAN: ____________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________ PHONE: ____________

NAME/RELATIONSHIP: ____________________ PHONE: ____________

NAME/RELATIONSHIP: ____________________ PHONE: ____________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Parent/Guardian Permission for Assistance with Over-the-Counter (OTC) Medication Form

School Year: ______________ **Student Name:** ____

Non-prescription Over-the-Counter (OTC) Medication

The parent or guardian must submit written authorization for the student to receive, self-administer (under staff supervision) or get assistance with over-the-counter medication each school year. Please submit a form for each medication requested.

Medication must be supplied to the health office by the parent in an original, labeled container. The medication must be appropriate for age and administration must follow package guidelines (any deviation requires licensed prescriber's authorization).

The student is to notify the Health Service Office under the following circumstances:

- Symptoms continue or get worse after taking medication
- Suspect that s/he is experiencing side effects from the medication

I give permission for a trained staff member to assist my child ____.
(Student's Name)
with administration of the following over-the-counter medication:

Information about the medication is as follows:

- Name of medication:

  ____

- Dose (amount to be taken):

  ____

- Time to be taken (if taken only as needed, please describe symptoms under which it should be given):

  ____

- How it is taken (example: swallowed; drops to right eye):

  ____

The following are any allergies or health conditions my child has: ____

____

Parent/Guardian Signature: ____ **Date:** _______________

Parent/Guardian Name (printed):_______________________________________