WESTMINSTER CHRISTIAN ACADEMY

Medication Form

20___-20___

Medications, whether over-the-counter or prescription, will only be dispensed with permission of a parent. Medication sent to school with a student must be stored in the clinic. The clinic does not stock medication so you must send each medication in the original container and labeled with the student's name and dosage.

STUDENT NAME:_____**GRADE**_____

Prescribed Medicines to be given at school **daily**

Name & Strength of Med	Dose/Amt	Times to Administer	Special Instructions	Sign-In Date	Sign-Out Date

Prescription & Over-the-Counter Medicines to be given **as needed**

Name & Strength of Med	Dose/Amt	For What Conditions?	Special Instructions	Sign-In Date	Sign-Out Date

I give permission for Westminster Christian Academy to give these medications as prescribed and directed.

_____

Signature of Parent/Guardian

*You may contact me at the following phone numbers: _____

Nov 2016

Prescription & Over-the-Counter Medicines to be given **as needed**

Name & Strength of Med	Dose/Amt	For What Conditions?	Special Instructions	Sign-In Date	Sign-Out Date

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School: _____**

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list: _____** Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage: _____Route: _____**

Frequency/Time(s) to be given: _____ **Start Date: ___/____/____ Stop Date: ___/___/___**

Reason for taking medication: _____
Potential side effects/contraindications/adverse reactions: _____
Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐
Is self- medication permitted and recommended? Yes ☐ No ☐
If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.
Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____Phone: ( ) _____-_____ Fax: _____-_____

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____Date: ___/___/___ Phone: ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/_____ Phone: ( ) _____-_____

revised 5/2014

SCHOOL YEAR: _____

SCHOOL MANAGEMENT PLAN - SEVERE ALLERGY TO: _____

Student also has ASTHMA? ☐ YES ☐ NO

Section 1 – Parent (Please Print):

Student Name: _____ DOB: _____ Wt: _____

Other allergies/triggers: _____ School: _____ Gr. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. ____

Parent Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II –Physician (Please Print)

IF YOU SEE THIS…	DO THIS…
Contact with or ingestion of allergen with no symptoms	1. Administer medication? ❑ Yes ❑ No Medication: _____ Medication dosage:_____ 2. Call parent or emergency contact 3. Observe student for ____minutes before return to class 4. Recheck student in 1 hour.
Symptoms of mild or early allergic reaction: • Itching • Hives • ***No Respiratory Distress***	1. Administer medication? ❑ Yes ❑ No Medication: _____ Medication Dosage: _____ 2. Other: _____
Symptoms of **severe allergic reaction**: • Mouth tingling • Respiratory distress: cough, wheeze, stridor • Weak pulse, low BP, pallor • Abdominal cramps, nausea	Administer Epinephrine? ❑Yes ❑ No ❑ Epipen: ❑0.3 mg ❑0.15 mg ❑ Twinject: ❑0.3 mg ❑0.15 mg ❑ Auvi-Q: ❑0.3 mg ❑ 0.15 mg **Follow instructions for administration as illustrated on box.** **1. Call 9-1-1** 2. Call parent/emergency contact 3. Remain with student until EMS personnel arrive 4. Give used autoinjector, to EMS personnel, if administered

*** ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER.**

When on field trips, the autoinjector should not be left in a backpack on the bus or with a teacher not with the student.

If student "self-carries" and "self-administers" medication, may a "back up" dose be kept with school nurse? ❑ Yes ❑ No

The severity of symptoms can change quickly and potentially progress to a life threatening situation.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.

I give permission for the release of my child's medical information, in the event of an emergency.

Physician/Prescriber's Signature _____ Date _____

School Nurse's Signature _____ Date _____

Parent's Signature _____ Date _____

Staff Signature (s) _____ Date _____

FOR SCHOOL NURSE USE ONLY

Medication	Self Carry?	Self Administer?	Expiration	Location of Medication

Revised: 07/2014