St. Joseph Montessori School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions.
    - The label must match what is on the Medication Authorization Form.
    - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
    - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form must be completed.**

  Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, ointments, vitamins and supplements.)

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

- ***All unused medication must be picked up by the parent/guardian on the last day of school. All expired medication will be discarded.***

St. Joseph Montessori School

Epinephrine Auto-Injector Medication
to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ Grade _____ School Year_____

Home Address_____ Date of Birth _____

Healthcare Provider to Complete:

I verify this medication has been prescribed for above student in the event of signs or symptoms of an allergic reaction and/or suspected exposure to the following allergen(s): _____

Signs or symptoms _____

Medication_____ Dosage_____ Route_____

Beginning Date _____ Expiration Date_____ or end of school year

CALL 911 when medication is administered. Repeat dose if medication does not produce relief ☐yes ☐no

Other medications prescribed to this student (home & school) _____

THIS SECTION IS ONLY FOR THE PERMISSION TO SELF CARRY:

I provided the student with training in the use of an auto-injector and he/she has demonstrated its proper use. ☐ yes ☐ no

The student is capable of possessing and self-administering the auto-injector per ORC 3317.716 and 3313.718. ☐ yes ☐ no

Per state law, I prescribed a back-up auto-injector to be kept at school for as needed use by trained staff. ☐yes ☐no

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address _____

_____

Phone Fax

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____

Phone Numbers _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's epinephrine auto-injector will be stored in the school medication cabinet to ensure its availability and will have the assistance of trained staff as needed.

- If my student is determined capable to self-carry and self-administer by myself, the healthcare provider and the school nurse, then I authorize my student to carry and use their epinephrine auto-injector as prescribed above, at school and school events: ☐yes ☐no.
  - I will instruct my child to inform school staff if he/she has used the auto-injector so school staff can immediately call 911.
  - I agree to provide the school with backup dose of epinephrine as required by law.

- I understand emergency medical service will be called if the epinephrine auto-injector is used. I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Saint Joseph Montessori School staff to communicate with the student's healthcare provider as needed.
- I give permission for this information to be shared with school staff who supervise my child during the school day.
- I release and agree to hold the Board of Trustees, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____

☐ ELEMENTARY

☐ SECONDARY

▮ BOTH

☐ POLICY **5141.35**

▮ REGULATION

STUDENTS

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:	**Give checked medication:**	
If a food allergen has been ingested but *NO symptoms:*	☐ Epinephrine	☐ Antihistamine
Mouth: itching; tingling; swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin: hives; itchy rash; swelling of face or extremities	☐ Epinephrine	☐ Antihistamine
Gut: nausea; abdominal cramps; vomiting; diarrhea	☐ Epinephrine	☐ Antihistamine
Throat: tightening of throat; hoarseness; hacking cough *	☐ Epinephrine	☐ Antihistamine
Lung: Shortness of breath; repetitive coughing; wheezing *	☐ Epinephrine	☐ Antihistamine
Heart: weak or thready pulse; low blood pressure; fainting; pale; blueness *	☐ Epinephrine	☐ Antihistamine
Other: _____ *	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (more than one of the above areas affected) give	☐ Epinephrine	☐ Antihistamine

*Potentially life threatening. Severity of symptoms can quickly change.

Administer Epinephrine autoinjector: inject intramuscularly into outer thigh. Dosage: _____ 0.15mg _____ 0.30mg
Anithistamine: _____dose:_____orally every _____hours.
Rescue Inhaler:_____ puffs:_____ Inhaled every: _____hours
May repeat:_____after 5-15 minutes as needed.

IMPORTANT: Asthma inhalers and antihistamines cannot replace epinephrine!

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent_____ Phone Number(s) _____
4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)