



Student Information

Student Name:	Birth Date:	Place Student Picture Here
Student Address:	Phone:	
School:	Grade/Teacher:	

Parent/Guardian Authorization (All parents to complete)

- [1] As the Parent / Guardian of this student: I authorize an employee of the school board to administer the prescribed medication at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
- [2] I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
- [3] I also authorize CHES Christian School's registered nurse to talk with the prescriber or pharmacist to clarify medication order.
- [4] I give permission for this information to be sent to the school via facsimile.
- [5] Medication form must be received by the principal, his/her designee, and/or CHES Christian School's registered nurse.
- [6] I understand that the medication must be in the **original** container and be properly labeled with the students name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration.

Stock epinephrine auto injectors will not go on field trips.

Parent/Guardian Name: _____ Phone #1: _____ Phone #2: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Self-Carry Authorization (Only complete if student is going to self-carry)

- [1] As the Parent/Guardian of this student: **I authorize** my child to possess and self-administer an epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. **I will provide a backup dose of the medication to the school principal, his/her designee, and/or CHES Christian School's registered nurse as required by law. (ORC 3313.718) Stock epinephrine auto injectors will not go on field trips.**
- [2] As the Parent/Guardian of this student: I authorize my child to possess and self-administer antihistamine as needed for allergy plan. Medication must be in properly labeled containers and in the amount needed for this care plan.
- [3] As the Parent/Guardian of this student: I understand that if epinephrine and/or antihistamine is self-administered, the student must notify the School Nurse or school employee.

Parent/Guardian Signature: _____ Date: _____

Special considerations and precautions for school activities, sports, field trips: Staff member in charge of the school sponsored event will be trained by the school's registered nurse in the administration of epinephrine auto injector. The medication will be provided to the staff member for safe storage in locked medication bag with precautions that the epinephrine auto injector will be kept at room temperature (59-86 degrees), out of extreme cold and heat, and kept out of direct sunlight. Staff members must have access to a phone.

*****MUST HAVE MEDICATION AUTHORIZATION FORM ON BACK COMPLETED BY PHYSICIAN *****

MEDICATION ORDERS
To be completed by physician

Student Name:	Birth Date:
ALLERGIC TO:	

[] If checked, give epinephrine immediately if student reports exposure (touch, smell, insect sting) to known allergen.

[] If checked, give epinephrine immediately if student reports ingestion of allergen.

9-1-1 will be called if epinephrine is administered, used auto injector will be given to EMS provider

<p>FOR ANY (1 or more) OF THE SEVERE SYMPTOMS:</p> <table style="width:100%; border: none;"> <tr> <td style="width:25%; padding: 5px;">LUNG Short of breath, wheezing, repetitive cough</td> <td style="width:25%; padding: 5px;">HEART Pale, blue faint, weak pulse, dizzy</td> <td style="width:25%; padding: 5px;">THROAT tight, hoarse, trouble breathing/swallowing</td> <td style="width:25%; padding: 5px;">MOUTH Significant swelling of the tongue and/or lips</td> </tr> <tr> <td style="padding: 5px;">SKIN Many hives over body, widespread redness</td> <td style="padding: 5px;">GUT Repetitive vomiting, severe diarrhea</td> <td style="padding: 5px;">Other Feeling something bad is about to happen, anxiety confusion</td> <td style="padding: 5px;">Or a combination of symptoms from different body areas</td> </tr> </table> <p>1. INJECT EPINEPHRINE IMMEDIATELY 2. CALL 9-1-1</p>	LUNG Short of breath, wheezing, repetitive cough	HEART Pale, blue faint, weak pulse, dizzy	THROAT tight, hoarse, trouble breathing/swallowing	MOUTH Significant swelling of the tongue and/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	<p align="center">MILD SYMPTOMS</p> <table style="width:100%; border: none;"> <tr> <td style="width:25%; padding: 5px;">NOSE: itchy/runny nose, sneezing</td> <td style="width:25%; padding: 5px;">MOUTH: itchy mouth</td> <td style="width:25%; padding: 5px;">SKIN a few hives, mild itch</td> <td style="width:25%; padding: 5px;">GUT mild nausea/discomfort</td> </tr> </table> <hr/> <p align="center">FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.</p> <hr/> <p align="center">FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA:</p> <ol style="list-style-type: none"> 1. Administer antihistamine as ordered 2. Stay with student and notify emergency contacts 3. Watch closely for changes. If symptoms worsen, give epinephrine. 	NOSE: itchy/runny nose, sneezing	MOUTH: itchy mouth	SKIN a few hives, mild itch	GUT mild nausea/discomfort
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<p>EPINEPHRINE: inject intramuscularly</p> <p>Circle one: 0.15mg 0.30 mg</p> <p>Date to begin: _____ Date to end: _____</p> <p>Adverse reactions for student prescribed _____</p> <p>_____</p> <p>Adverse reactions for student NOT prescribed _____</p> <p>_____</p> <p>Special instructions _____</p> <p>_____</p> <p>Procedures for school employees if student is unable to administer the medication or if it does not produce the expected relief _____</p> <p>_____</p>	<p>ANTIHISTAMINE: (name & dose in mg)</p> <p>_____</p> <p>Route to be given _____</p> <p>Time & frequency to be given _____</p> <p>_____</p> <p>Date to begin: _____ Date to end: _____</p> <p>Adverse reactions for student prescribed _____</p> <p>_____</p> <p>Adverse reactions for student NOT prescribed _____</p> <p>_____</p>												

_____ As the prescriber, I have determined that this student **is capable** of possessing and using the auto injector and antihistamine as needed for treatment of an allergic reaction. The student has been provided training in the proper use of the auto injector and antihistamine administration.

_____ As the prescriber, I have determined that this student **is not** capable of possessing and using this auto injector appropriately and administration of this medication may be supervised by medically untrained personnel, it is requested that the medication be given at school by school personnel.

Physician Name: _____ Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____