

# Notice to Parents Regarding Medication Policy



Dear Parent/Guardian:

To protect your child's safety, the school licensed practical nurse and/or health aide (as designated by the principal) will adhere to the following medication policy. It is required that BOTH parent AND physician's signatures are on file before any prescription.

Although this may cause some inconvenience, we believe this policy is best for the continued protection of your child's safety and therefore must be followed. If we do not have your written permission and the written permission of your physician, the medication will not be given. Permission forms can be obtained by contacting your school licensed practical nurse or health aide or the school office.

For your child to receive any medication at school, please follow below medication policy:

- All Action/Care Plans will need to be submitted with a Medication Consent form.
- Administration consent form must be completed and signed by physician, parent, or legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- New permission forms must be re-submitted each school year and are necessary for any changes in medication orders.
- Over the counter medications (OTC) forms are required to be filled out and signed by parent/guardian annually. No OTC medication(s) will be administered without written consent.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Only students with written authorization from their physician and parents are allowed to self-carry medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- The medication and the signed permission forms must be brought to the school by the parent or guardian and delivered to the campus clinic health aide. Students are not to be sent to campus with medications.
- Wherever possible, please include a photo of your child with the permission form.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- When the medication is almost completed, please send the refill to school promptly.
- If your child is taken off medication, will no longer receive it at school, or if the prescription otherwise changes, please provide a dated, written note with updated prescription information of such changes as soon as possible. If medication is not picked up from the school office within ten (10) days, it will be properly disposed of.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Please contact the principal or his/her designee if you have any questions.  
Thank you for your cooperation.

# Aviso a los padres sobre la política de medicamentos



Estimado Padre / Tutor:

Para proteger la seguridad de su hijo, la enfermera practicante con licencia de la escuela y/o el asistente de salud (según lo designe el director) se adherirá a la siguiente política de medicamentos. Se requiere que AMBOS padres y las firmas del médico estén archivadas antes de cualquier receta.

Aunque esto puede causar algunos inconvenientes, creemos que esta política es la mejor para la protección continua de la seguridad de su hijo y, por lo tanto, debe seguirse. Si no tenemos su permiso por escrito y el permiso por escrito de su médico, no se administrará el medicamento. Los formularios de permiso se pueden obtener comunicándose con la enfermera práctica autorizada o el asistente de salud de su escuela o con la oficina de la escuela.

Para que su hijo reciba cualquier medicamento en la escuela, siga la siguiente política de medicamentos:

Todos los planes de acción/cuidado deberán presentarse con un formulario de consentimiento de medicamentos.

- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los nuevos formularios de permiso deben volver a presentarse cada año escolar y son necesarios para cualquier cambio en las órdenes de medicamentos.
- Los formularios de medicamentos de venta libre (OTC) deben ser llenados y firmados por el padre/tutor anualmente. No se administrarán medicamentos de venta libre sin el consentimiento por escrito.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- El medicamento y los formularios de permiso firmados deben ser llevados a la escuela por el padre o tutor y entregados al asistente de salud de la clínica del campus. Los estudiantes no deben ser enviados al campus con medicamentos.
- Siempre que sea posible, incluya una foto de su hijo con el formulario de autorización.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- Cuando el medicamento esté casi terminado, envíe la recarga a la escuela de inmediato.
- Si a su hijo se le retira el medicamento, ya no lo recibirá en la escuela, o si la receta cambia de otro modo, proporcione una nota escrita con fecha con información actualizada de la receta de dichos cambios tan pronto como sea posible. Si el medicamento no se recoge en la oficina de la escuela dentro de los diez (10) días, se desechará correctamente.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Comuníquese con el director o su designado si tiene alguna pregunta.  
Gracias por su cooperación.

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

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

**PLACE  
PICTURE  
HERE**

**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

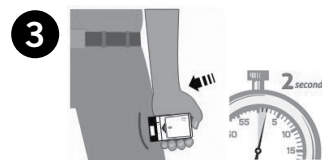
Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

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

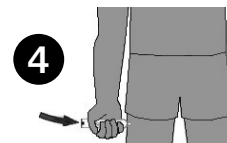
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



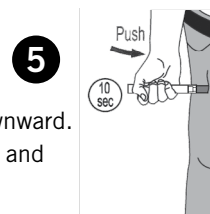
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 ADRENALCLICK®), 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: \_\_\_\_\_



# MEDICATION ADMINISTRATION CONSENT FORM

## STUDENT INFORMATION

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_

List any known drug allergies/reactions: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## PHYSICIAN AUTHORIZATION (To be completed by physician/licensed prescriber)

Name of Medication: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) and Interval to be administered: \_\_\_\_\_

Date of Authorization: \_\_\_\_\_ Begin/End Dates: \_\_\_\_\_

Special Instructions for Administration and Storage of Medication: \_\_\_\_\_

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes ☐ No ☐

If yes, please provide recommended administration time(s): \_\_\_\_\_

Is the medication a controlled substance? Yes ☐ No ☐ Does medication require refrigeration? Yes ☐ No ☐

Special Instructions or Storage: \_\_\_\_\_

Potential Side Effects/Contraindications/Adverse Reactions: \_\_\_\_\_

Treatment Order in the event of an adverse reaction: \_\_\_\_\_

*(Attach additional sheet or use the back of this form if necessary)*

Provider Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

## PARENT AUTHORIZATION (To be completed by parent/guardian)

- I authorize the delegated personnel the task of assisting my child with medication administration.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Only medication prescribed and provided by the United States will be administered in school.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Administration consent form must be completed and signed by physician, parent, or legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- Only students with written authorization from their physician and parents are allowed to self-carry medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Secondary Contact Number: \_\_\_\_\_ Date: \_\_\_\_\_



# MEDICATION ADMINISTRATION CONSENT FORM

## STUDENT INFORMATION

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Nombre del Estudiante) (Fecha de Nacimiento)  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
(Dirección) (Ciudad/estado/código postal)  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_  
(Escuela) (Grado) (Maestro/a) (Año escolar)  
List any known drug allergies/reactions: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_  
(Alergia/Reacción Conocida a Medicamentos) (Altura) (Peso)  
Parent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
(Nombre del Padre) (Número de Teléfono)

## PHYSICIAN AUTHORIZATION (To be completed by physician/licensed prescriber)

Name of Medication: \_\_\_\_\_ Reason for taking: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) and Interval to be administered: \_\_\_\_\_  
Date of Authorization: \_\_\_\_\_ Begin/End Dates: \_\_\_\_\_  
Special Instructions for Administration and Storage of Medication: \_\_\_\_\_  
Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes ☐ No ☐  
If yes, please provide recommended administration time(s): \_\_\_\_\_  
Is the medication a controlled substance? Yes ☐ No ☐ Does medication require refrigeration? Yes ☐ No ☐  
Special Instructions or Storage: \_\_\_\_\_  
Potential Side Effects/Contraindications/Adverse Reactions: \_\_\_\_\_  
Treatment Order in the event of an adverse reaction: \_\_\_\_\_  
(Attach additional sheet or use the back of this form if necessary)  
Provider Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTORIZACIÓN DE LOS PADRES (Para ser completado por el padre/tutor)

- Autorizo al personal delegado la tarea de asistir a mi hijo en la administración de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Sólo se administrarán en la escuela los medicamentos prescritos y proporcionados por los Estados Unidos.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_  
(Nombre del Padre de Familia / Guardian) (Firma del Padre / Tutor)  
Secondary Contact Number: \_\_\_\_\_ Date: \_\_\_\_\_  
(Número de Contacto Secundario) (Fecha)