North Mahaska Community School District
Medication Consent Form

Student's Name_____ **Date of Birth** ____/____/____
School_____ **Grade/Teacher** _____

School medications and health care services are administered following these guidelines:

- Parent signed and dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed, or
- The medication is in the manufacturer's labeled container.
- The medication label contains the student's name, name of medication, directions for use and date.
- Authorization is renewed annually and immediately if the parent notifies the school nurse that changes are necessary.

Any change in the prescription (dosage, time, etc.) must be in writing from the physician.

1. Medication _____ Dosage _____ Route _____ Time given at school _____

Administration Instructions/ Special Directions _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Fax Number _____

2. Medication _____ Dosage _____ Route _____ Time given at school _____

Administration Instructions/ Special Directions _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Fax Number _____

3. Medication _____ Dosage _____ Route _____ Time given at school _____

Administration Instructions/ Special Directions _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Fax Number _____

I request the above student be given the medication(s) listed above at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record be maintained. To the best of my knowledge, the student has not experienced any previous side effects from the listed medication(s).

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

I agree that qualified school personnel may contact the prescriber as needed by phone, mail or fax to clarify medication administration instructions and/or to exchange with the provider efficacy concerns relating to expected therapeutic results of above listed medication(s). I further agree that medication information may be exchanged with qualified school personnel who need to know in accordance with the Family Education Rights and Privacy Act (FERPA).

Parent/Guardian Signature _____ Date _____

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

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

Extremely reactive to the following foods: _____

THEREFORE:

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

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

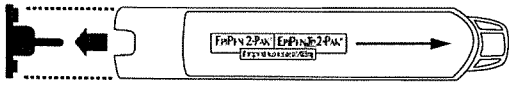
_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

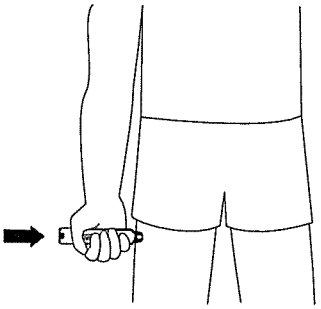
TURN FORM OVER **Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011**

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**



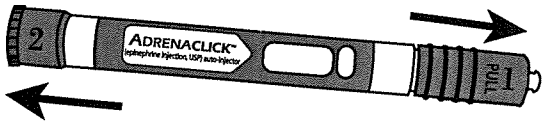
- **Hold orange tip near outer thigh (always apply to thigh)**

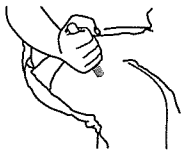


- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions





Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____