North Mahaska Community School District Medication Consent Form

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 is renewed annually and immediately if the parent notifies the school nurchanges are necessary. *Any change in the prescription (dosage, time, etc.) must be in writing from the physician. *Any change in the prescription (dosage, time, etc.) must be in writing from the physician. *Administration instructions' Special Directions *Time given at school *Administration instructions' Special Directions *Prescriber Name Prescriber Phone Number Prescriber Fax Num *Administration instructions' Special Directions *Administration instructions' Special Directions *Administration instructions' Special Directions *Prescriber Name Prescriber Phone Number Prescriber Fax Num *Administration instructions' Special Directions *Administration instructions' Special Directions *Prescriber Name Prescriber Phone Number Prescriber Fax Num *Administration instructions' Special Directions *Administration instructions' Special Directions *Administration instructions' Special Directions *Administration instructions and a record be maintained. To the best 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 where the person administering the medication acts as an ordinarily reasonably prudent p would under the same or similar circumstances. I agree to provide safe delivery of 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 clarify m	Student's Name	Date of Birth/
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 u date. Authorization is renewed annually and immediately if the parent notifies the school nur changes are necessary. *Any change in the prescription (dosage, time, etc.) must be in writing from the physician. T. Medication Dosage Route Time given at school Administration instructionar Special Directions Prescriber Name Prescriber Phone Number Prescriber Pax Num Z. Medication Dosage Route Time given at school Administration instructionar Special Directions Prescriber Name Prescriber Phone Number Prescriber Fax Num Administration instructions/ Special Directions Prescriber Name Prescriber Phone Number Prescriber Fax Num Trequest the above student be given the medication(s) listed above at school and school activities by quistiff, according to the prescription or nonprescription instructions and a record be maintained. To the best 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 administrat medication where the person administering the medication acts as an ordinarily reasonably prudent p would under the same or similar circumstances. I agree to provide safe delivery of 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 clarify medication and maintstration instructions and/or to exchange with the provider efficacy con relating to expected therapeutic results of above listed medication(s). I further agree that medication formation may be exchanged with qualified school personnel who-need to know in accordance wifemilia to a provide and provider of the administration instruct	School	Grade/Teacher
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U A CARACTER CONTRACTOR CONTRACTO	Parent/Guardian Signature	Date

Food Allergy Action Plan

Emergency Care Plan

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:

Short of breath, wheeze, repetitive cough LUNG:

Pale, blue, faint, weak pulse, dizzy, HEART:

confused

THROAT: Tight, hoarse, trouble breathing/swallowing

Obstructive swelling (tongue and/or lips) MOUTH:

Many hives over body SKIN:

Or combination of symptoms from different body areas:

Hives, itchy rashes, swelling (e.g., eyes, lips) SKIN:

Vomiting, diarrhea, crampy pain GUT:

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth

SKIN:

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



1. INJECT EPINEPHRINE **IMMEDIATELY**

Place Student's

Picture

- 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.

1. GIVE ANTIHISTAMINE

- 2. Stay with student; alert healthcare professionals and parent
- 3. If symptoms progress (see above), USE EPINEPHRINE
- Regin monitoring (see hoy

Medications/Doses	7	below)
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.

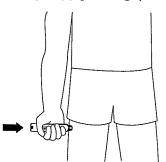
Parent/Guardian Signature	Date	Physician/Healthcare Provider Signature	Date
Parent/Guardian Signature	Date	Filysician/Healthcare Flovider Signature	Date

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



DEY" and the Dey logo, EpiPen", EpiPen 2-Pak", and EpiPen Jr 2-Pak* are registered trademarks of Dey Pharma, L.P.

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: Parent/Guardian:	Phone: () Phone: ()
Other Emergency Contacts	
Name/Relationship:	Phone: ()
Name/Relationship:	Phone: ()