

**EASTERN SCHOOL DISTRICT
FORM A - PARENT/GUARDIAN MEDICATION CONSENT AND RELEASE
FORM**

(To be completed by Parent/Guardian)

Student Name: _____ D.O.B: _____

Address: _____

Emergency Contact(s): _____ Tel #: _____

School: _____ School Year: _____

Grade/Level: _____ Room/Class: _____ Teacher: _____

Prescribed Medication:

I hereby request, authorize and empower the Eastern School District to administer medication as described herein or treatment as described in Form B (see attached) to the student named above. I release the Eastern School District and any staff member of the student's school from any legal liability that may result from the administration of such medication or the giving of such treatment. I also agree to indemnify the Eastern School District against claims at any time made by the student named or by any other party arising

out of the administration of medication or treatment described herein to my child.

I further acknowledge awareness that school staff members are not medically trained personnel and that my expectations of school personnel in the knowledge and administration

of medication to my child or any other child shall be no greater than that of their professional field.

PARENT/GUARDIAN PERMISSION:

I request and give consent to allow a staff member to administer this prescribed medication

at school with the in full realization that that person is not a medically trained person.

Signature of Parent/Guardian Date

Signature of Parent/Guardian Signature of Witness

**EASTERN SCHOOL DISTRICT
FORM B - PHYSICIAN'S REPORT**

Student Name: _____ D.O.B.: _____

Address : _____ MCP#: _____

Parent/Guardian(s): _____

Medical condition requiring treatment during school hours: _____

TYPE OF IN-SCHOOL INTERVENTION NECESSARY;

1. Medication(s):

Medication

Prescribed

Dose

Frequency

Required Time of

Administration

Method of

Administration

Purpose of

Medication

2. Other (be specific):

3. CONSIDERATIONS

a. Possible side effects of medication(s)/treatment and remedial action for side effects

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FORM B - PHYSICIAN'S REPORT
(CONTINUED)**

b. Type of storage and safe keeping required for medication _____

c. Will it be detrimental to the student's health if a single dose/treatment is omitted?

Yes ____ No ____

d. Please check the appropriate box to complete this statement:

Persons administering the medication/treatment as described above

____ **do need** to have had medical training or certification by the Community Health Nursing Division

____ **do not need** to have had medical training or certification by Community Health Nursing Division

3. The student named above must have this medication/procedure administered/performed during school hours in order to be able to attend school

Yes ____ No ____

4. Is this student able to administer his/her own medication? Yes ____ No ____

If yes, give details:

Signature of attending physician

Name of attending physician and telephone numbers

**EASTERN SCHOOL DISTRICT
FORM F - SELF-ADMINISTRATION OF MEDICATION BY
STUDENT**

A. TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ Address: _____

Parent/Guardian name(s): _____ Tel.#'s: _____

Emergency Contacts: _____ Tel.#'s: _____

School: _____ Grade/Level: _____

I hereby consent to my child administering his/her own medication as described herein. I release the Eastern School District and any employee from any legal liability with respect to my child's administration of his/her medication. I also agree to indemnify the Eastern School District against any claims made by the student or by any party arising out of my child's self administration of medication or treatment described herein.

I have discussed the importance of the responsible security and handling of this medication with my child.

Signature of Parent/Guardian Date

Signature of Witness-Principal/Vice Principal Date

Please Note: This will need to be witnessed by an employee of the Eastern School District.

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**EASTERN SCHOOL DISTRICT
FORM F - SELF-ADMINISTRATION OF MEDICATION BY
STUDENT (CONTINUED)**

B. TO BE COMPLETED BY PHYSICIAN

Medical condition requiring treatment _____

—
Prescribed Medication, Dosage and Daily Schedule of Administration:

—

—

—
The student named above is capable of administering his/her own medication without any supervision from any employee of the Eastern School District staff and is capable of keeping his/her own medication in his/her possession for this purpose.

Signature of Attending Physician Telephone Number(s)

C. FOR OFFICE USE ONLY

Date Submitted to Office: _____ Principal's Signature: _____

Teacher(s) Notified: ____ No ____ Yes Date

**EASTERN SCHOOL DISTRICT
CONSENT FORM FOR STUDENTS WITH LIFE-THREATENING FOOD ALLERGIES**

_____ (student's name) has been identified as having a serious allergy and the school would like to take the following precautionary measures:

1. Post an Anaphylaxis Alert form complete with a photograph of your child, a description of the allergy, and an action plan in key locations in the school.
2. Provide all staff (including substitute teachers) with information concerning your child's allergy as described in the Anaphylaxis Alert form.
3. Identify students who have anaphylactic allergies to parent volunteers.

To assist the school in carrying out these precautionary measures, the school requests the following:

1. An Anaphylaxis Alert form with an individualized action plan, signed by a physician.
2. One up-to-date photograph of your child that can be photocopied clearly for use on the forms.
3. All medications listed on the action plan, including two auto-injectors (EpiPens®), labeled with the student's name and the expiry date of the medication.

IMPORTANT: If the parents provide the school with only one EpiPen®, it will be kept in a secure, accessible area as designated by the school administration.

Please sign below to indicate your consent to the above measures and return the form to the Principal.

Please contact the school if you have any concerns.

I, _____, parent/guardian of _____ (student) attending _____ school, hereby consent to the school taking the precautionary measures listed in items one to three above, and further agree to provide the school with the items referred to in items numbered four to six above.

(date) (signature of parent/guardian)

**EASTERN SCHOOL DISTRICT
ADMINISTRATION of EMERGENCY MEDICATION**

Student's Name _____ Homeroom/Teacher _____

Student Address _____

Name of School _____ Name of Principal _____

Location of Emergency Medication _____

The above named student has a medical condition known as _____

that may require treatment with **emergency medication(s)** during school hours.

Emergency Medication Information

Name/type of medication: _____

Dosage/amount to be given: _____

Method of administration: _____

Frequency/times to be administered: _____

Duration: _____

Type of storage required for Medication: _____

Anticipated reaction to medication (symptoms, side effects, etc.): _____

Request

We are writing to request that the principal or designate administer the medication known

as _____ to _____

(Name of Medication) (Name of Student)

in the event that he/she experiences _____

(Name of Medical Condition)

Physician's Signature / Date Parent (Guardian) Signature / Date

OPTIONAL:

The student named above may keep his/her medication in his/her possession. I have discussed the importance of the responsible security and handling of this medication with my child. In an Emergency, the student may administer his/her

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ANAPHYLAXIS ALERT
Life Threatening Allergies

Student _____ Grade/Teacher _____

LIFE THREATENING ALLERGIES TO:

Exposure to minute amounts of this allergen can be dangerous to the child. At all times this child must AVOID:

A CHILD WITH A LIFE THREATENING ALLERGY MUST ALWAYS HAVE ADRENALINE (EPIPEN/ Ana-Kit)

Eating Rules/Activity Rules:

<p>Contacts</p> <p>Parent / Guardian:</p> <p>Tel: _____</p> <p>Parent / Guardian:</p> <p>Tel: _____</p> <p>Hospital:</p> <p>Tel: _____</p>
--

Photo of
Child

POSSIBLE SYMPTOMS OF ANAPHYLAXIS: (Check symptoms commonly experienced by the child, but all symptoms are possible)

- ___ Tingling in mouth
- ___ Swelling eyes, lips, face, tongue
- ___ Vomiting / stomach upset
- ___ Feeling of fear / anxiety
- ___ Flushed face / body
- ___ Coughing / Choking
- ___ Hives / itching
- ___ Wheezing
- ___ Dizziness / unsteadiness
- ___ Difficulty breathing / swallowing
- ___ Less of consciousness
- ___ Other _____

ACTION PLAN:

1. Use ADRENALINE immediately at first sign of symptoms. (Give into outer thigh and hold in place for 10 seconds)
2. Have child spit out food and rinse mouth. Wash contact area.
3. Give additional medication, if any: _____
4. Transport child immediately to medical facility by _____ car or _____ ambulance (call dispatcher child is having an anaphylactic reaction)
5. Have someone telephone the medical facility to inform them of the incoming child.
6. Administer additional ADRENALINE during transport every 15-20 minutes, if available, if breathing difficulties are present.
7. Suggest the child be monitored in medical facility for at least 8 hours, even if symptoms subside. Symptoms may reoccur.

Date: _____ Physician Signature: _____
 HRP: PSC/ALLERGIES, Parent Support Group, Long Association, March 1999

ANAPHYLAXIS ALERT FORM

ASTHMA INFORMATION

Asthma Triggers: _____

Symptoms of Asthma Episode: _____

Medication Provided for Asthma Relief (Where is medication located?): _____

Instructions for Asthma Episode: _____

**EASTERN SCHOOL DISTRICT
ANAPHYLAXIS ALERT FORM FOR BUS DRIVERS**

In the event of an Anaphylactic Reaction the bus driver must:

- Bring the bus to a complete stop in a safe area;
- Advise all passengers to remain seated;
- Ask for assistance in removing the allergic food from the bus;
- Administer the auto-injector (EpiPen®) - if authorized and trained;
- Follow the Emergency Response Procedures, which includes contacting emergency officials for assistance.

Student Information:

Student's Name: _____

School: _____

Grade: _____

Address: _____

Phone Number: _____

Bus Route/Name: _____

Photo

Emergency Contacts:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Family Doctor: _____ Phone Number: _____

Medical Information:

Anaphylactic To:

Carries EpiPen

**EASTERN SCHOOL DISTRICT
SPECIAL FIELD TRIP CONSENT FORM**

Conditions of Field Trip:

- The school is aware that your child has a life-threatening allergy.
- The teacher in charge of the field trip has received an in-service on Anaphylaxis and the administration of emergency medication (EpiPen®).
- This teacher is responsible for bringing the emergency medication(s) on the field trip for primary/elementary students and for ensuring that junior/senior high students carry it.

Name of teacher in-charge of the field trip: _____

The student will be traveling by (please check () the appropriate boxes):

Bus Foot Other: _____

In the event of an Anaphylactic emergency, the teacher in-charge of the field trip will:

- administer the EpiPen®
- call local emergency officials (911 if applicable)
- ensure the student is transported to the nearest medical facility via ambulance
- contact the parents

Statement of Permission:

I have read the above conditions of the field trip and **give** permission for

_____ (student's name) to attend the field trip to

_____ with _____ (school's name)

on

_____ (date).

I will accompany my child on the field trip (please check ()): Yes No

Further Comments: _____

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Statement of Refusal:

I **do not** give permission for _____ (student's name) to attend the
field trip to