MEDICATION/TREATMENT AUTHORIZATION FORM -- ALLERGY

Name:____ **DOB:**_____________ **SCHOOL:** _________________________________

▸▸To be completed by PARENT/GUARDIAN--Parent/Guardian Permission◂◂

I hereby grant permission to the principal or his/her designee of ________________________________ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change**. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Parent/Guardian Name: ____ Relationship: ___________________

Emergency Phone: ___________________________ Home Phone: __________________________ Work Phone ________________________

Address: ____

Parent/Guardian Signature: ____ DATE: _________________

Parent/Guardian Printed Name: ____

▸▸To be completed by PRESCRIBING PHYSICIAN/Healthcare Provider (HCP)--MUST BE LICENSED in the State of Florida◂◂

Asthmatic Yes* ☐ No ☐ **ALLERGIES:** ____

* Higher risk for severe reaction

▸▸STEP 1: TREATMENT◂◂

Symptoms: Please circle all that apply. Give Checked Medication**:

** (To be determined by licensed health care provider authorizing treatment

Symptoms		
● If a food allergen has been ingested, but no symptoms:	☐ Epinephrine	☐ Antihistamine
● Mouth - Itching, tingling, or swelling of lips, tongue, or mouth	☐ Epinephrine	☐ Antihistamine
● Skin - Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
● Gut - Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
● Throat† - Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
● Lung† - Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
● Heart† - Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
● Other†	☐ Epinephrine	☐ Antihistamine
● If reaction is progressing (several of the above areas affected) give	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening

Medication/Dose/Route/Time (complete for ALL Medications):

ANTIHISTAMINE: give ____

EPINEPHRINE: give ____

Other: Including second dose of epinephrine, give____

INHALER: give____

Possible SIDE Effects (MUST BE COMPLETED): ____

Time medication given at home (if applicable): ______ Other medications given at home:______________________________

▸▸STEP 2: EMERGENCY CALLS◂◂

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

The student named in this document is under my medical supervision for the diagnosis described. I have prescribed the medication/treatment regimen above, which is necessary during school hours. I am aware that trained non-medical staff may administer this physician prescribed service. **This order is only effective for the school year: 20_____ -- 20_______**

DIAGNOSIS: ____

Type of Allergy

❑ **Medication** ❑ **Food**

______________________________ ______________________________

❑ **Environmental Allergens** ❑ **Insect Bites/Stings**

______________________________ ______________________________

Symptoms of Allergy

Check the box next to any of the following symptoms that child has experienced:

❑ Hives or giant hives
❑ Swelling of __________________
❑ Difficulty in breathing – wheezing
❑ Difficulty swallowing
❑ Shock
❑ Fainting – dizziness
❑ Other (Describe) ____
❑ Life-Threatening ALLERGIES:____

1. Has child ever been hospitalized for any allergic event? ❑ Yes ❑ No if Yes, Describe:

2. **Is medication required immediately after exposure to any allergy producing substance?**
   ❑ Yes** ❑ No **__**If "Yes" we must have the *Medication/Treatment Authorization Form for Allergies* on file at school.**__**

3. **If no medication is necessary, how should the school treat the allergic event?**
   Careful observation ❑ Yes ❑ No Call parent/guardian ❑ Yes ❑ No

If your child has a special dietary need, Champ's Café requires a copy of a **medical statement from a licensed health care provider that must include and address the following:**

- An identification of the medical or other special dietary condition that restricts the child's diet
- The food or foods to be omitted from the child's diet
- The food or choice of foods to be substituted

*If your child has a medical or special dietary need involving milk, such as lactose intolerance, a PARENT NOTE on file with the SCHOOL NURSE will allow the Food & Nutrition Services staff to substitute __**Lactaid Milk only**__ as a beverage with the meal. ***USDA does not permit juice to be provided instead of milk; Juice does not have the same nutrients as milk or Lactaid Milk; It is not a requirement for a child to take milk with a meal.***
Please have Healthcare Provider indicate dietary condition/medical diagnosis & special needs below:

____

____

● Medication EXPIRATION DATE to follow manufacturer's expiration date?	☐ Yes	☐ No
● Is medication needed during field trips?	☐ Yes	☐ No
● Is student authorized to carry and use/self-administer asthma inhaler?*	☐ Yes	☐ No
● Is student authorized to carry and use/self-administer epinephrine auto-injector?*	☐ Yes	☐ No
● Is student authorized to carry and use/self-administer pancreatic enzymes?*	☐ Yes	☐ No

***(physician must provide education on use)**

Other Information: ____

Licensed Physician/HCP's Name: ____________________________________ Credentials/Specialty ________________

Address: ____________________________________ Telephone:________________ FAX:__________________

Licensed Physician/HCP's Signature: ____ Date: ________________

MEDICATION/TREATMENT AUTHORIZATION FORM

Instructions: For medication/treatment administration during school hours-- see Requirements below.

State regulations and school board policy require that you and your child's doctor must provide written permission for any prescribed medications, including over-the-counter (OTC) medications and/or medical treatments.

The administration of prescribed medications/treatments to a student during school hours will only be permitted when the failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program. (CCPS Policy 5330)

- The Medication/Treatment Authorization Form on the reverse side of this document must be completed **ENTIRELY** and accompany any medication (either prescribed or OTC) to be given to your child at school. **Both a parent/legal guardian and the prescribing doctor/HCP MUST SIGN the form**. Staff will not administer medication to your child without this **written consent**. The section completed by the prescribing doctor **MUST BE LEGIBLE** or this form will be invalid.

- **Prescribed Medications:** must be hand carried by parent/guardian/authorized adult to the health clinic in a container with the original, unaltered prescription label attached. The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration date, patient name, the licensed prescriber's (doctor/HCP) name, medication name, dose , and instructions for administration.

  ****The medication in the container must match the label and all label information must match the Medication/Treatment Authorization Form on the reverse side of this document.**

  ****DO NOT SEND MEDICATIONS TO SCHOOL WITH YOUR CHILD--this is a violation of policy and may result in discipline.**

- **Over-the-counter (OTC) Medications:** must be hand carried by parent/guardian/authorized adult to the health clinic in the original, unopened store-issued container labeled with the student's full name, date of birth, and the dosage prescribed by the doctor written legibly.

- **The medication brought to the school health room must match the prescribed medication amount**. For example, if the prescribed amount is ½ tablet, then it is the responsibility of the pharmacy/parent to cut the tablets.
- ALL MEDICATION will be counted by the parent/guardian/authorized adult, verified by health clinic staff, and documented on the appropriate forms/electronic record.
- Albuterol, Asthma Inhalers, and Epinephrine Auto-Injectors must be delivered in the original box with the pharmacy label. Two pharmacy labels are required for boxes containing two Epinephrine Auto-Injectors.
- The RN/LPN at your child's school may need to call the prescribing doctor's office for medication/treatment clarification. Parents/guardians must provide contact information for their child's doctor/HCP using the student Emergency Card which must be completed and updated every year.
- A separate Medication/Treatment Authorization Form is required for each medication; a new Medication/Treatment Authorization Form is required every school year and for any order changes.
- Any medications not picked up at the end of the school year or when a medication is discontinued-will be discarded.