ZEELAND CHRISTIAN SCHOOL

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT / GUARDIAN

Student's Photo

I, the parent/guardian of _____ DOB _____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent/guardian, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours
   And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes
4. I will assume responsibility for safe delivery of the medication to school
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I give permission for my child to self administer rescue medication if approved by physician
7. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization

PLEASE COMPLETE ATTACHED ALLERGY ACTION PLAN, OR SUBMIT A CURRENT PLAN ALREADY ON FILE IN PHYSICIAN OFFICE.

I have discussed and developed a plan, with the school nurse, for appropriate support during school emergencies.

Signature of Parent/Guardian: _____Relationship: _____

Date: _____Emergency Contact Phone #_____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

 Your child's doctor will tell you to do what's best for your child.
This information should not take the place of talking with your child's doctor.

ZEELAND CHRISTIAN SCHOOL

334 W. Central Ave., Zeeland, MI 49464, Phone: (616)772-2609, Fax: (616)772-2706

SELF-ADMINISTRATION OF EPINEPHRINE STUDENT AGREEMENT

This order is valid for the school year (current) _____, including the summer session.

Student Name: _____ Date of Birth: _____Grade: _____

To be Completed by the Student:

I agree to:

- Follow my prescribing healthcare provider's medication orders.
- Carry my medication in its original container properly labeled with my name, the medication name, the medication dose and frequency of administration, the ordering physician's name and a current date (unexpired) for all prescription medications, or an intact label and current date for all non-prescription medications, labeled with my name.
- Carry a copy of my individualized healthcare plan with the medication.
- Carry, other than inhalers, only a day's supply of medication.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and all field trips.
- Notify the school nurse immediately following administration of my medication.

I understand that permission for self-carry/self-administration of my medication may be discontinued if I am unable to follow the safeguards established above.

Signature of Student:_____ Date:_____

For use by the Nurse:

- ☐ Student verbalizes correct dosage of medication
- ☐ Student able to verbalize allergic reaction/anaphylaxis symptoms
- ☐ Student is carrying medication appropriately with a copy of the individualized healthcare plan
- ☐ Student demonstrates proper technique for medication administration:

  For epinephrine:

  1. Removes injector from container if applicable.
  2. Removes safety cap(s)
  3. Checks medication through viewing window if applicable
  4. Demonstrates appropriate placement of injector for administration
  5. Explains how to administer epinephrine (follow audible device instructions or inject and hold for 3-10 seconds as applicable to administration device, massage site if applicable)
  6. Verbalizes will note time and save syringe for EMS
  7. Verbalizes will call 911
- ☐ Student verbalizes safe use of epinephrine (not sharing, alerting school staff member to contact nurse)

School RN: _____ Date: _____