Emergency Action Plan & Medication Authorization Packet

(A NEW packet must be completed **PRIOR** to the start of each new school year)

1. Packet Contents & Instructions

2. Emergency Action Plan

3. Medication Authorization Form* (**ANY/ALL** Medication(s) at School, One form per medication)
   * Requires Healthcare Provider and parent/guardian signature

4. Authorization for Emergency Medication Self-Carry Form* (if applicable)
   * Requires Healthcare Provider and parent/guardian signature

Medications should be brought to school by the parent in an original prescription bottle or the original bottle/box (for over-the-counter medications). Consider asking the pharmacist to provide two properly labeled containers (one for home, and one for school).

Any changes in medication, dosage, or time of administration shall be made through submission of a new, updated Medication Authorization Form with all required signatures. Faxed signatures from the parent/guardian and healthcare provider are acceptable.

MEDICAL CONDITION	Insert Current Picture of Scholar	LIST OF WHAT TO AVOID (Ex. NO PEANUTS)
_____ _____ _____ *Birthday:* _____ *Weight:* _____		_____ _____ _____ _____ _____

_____ _____ _____

School Year **STUDENT NAME** *Grade*

SPECIAL INSTRUCTIONS REGARDING DIETARY/ACTIVITY RESTRICTIONS: _____

_____

_____

ANY SEVERE SYMPTOMS TO BE AWARE OF: _____

_____

PROTOCOL FOR MEDICATION DISPENSION (EPI-PEN/INHAILER/ANY OTHER SPECIAL INSTRUCTIONS):

_____

_____

_____

KNOWN DRUG ALLERGIES: _____

Permission to post this Emergency Plan in common campus areas: ❑ **Yes** ❑ **No**

EMERGENCY CONTACT INFORMATION

_____	_____	_____	_____
Mother's Name	*Cell Phone*	*Work Phone*	*Home Phone*
_____	_____	_____	_____
Father's Name	*Cell Phone*	*Work Phone*	*Home Phone*
_____	_____	_____	_____
Additional Contact	*Cell Phone*	*Work Phone*	*Home Phone*

MEDICAL INFORMATION

_____	_____	_____
Doctor Name	*Facility Name*	*Phone Number*
_____	_____	_____
Allergist/Specialist Name	*Facility Name*	*Phone Number*

Permission to treat student even if parent can't be reached: ❑ **Yes** ❑ **No**

Socrates Academy Medication Authorization Form

Ph. (704) 321-1711 Fax. (704) 321-1714

Student Name: ____

Birth date: _____________________ Teacher/Grade: ____

In order to help protect your child's health, your consent **and** written authorization from a physician or health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines at school.

Parent or Guardian's Permission: I hereby give permission for my child (named above) to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve Socrates Academy and their agents and employees from any and all liability whatsoever that may result from my child taking this prescribed medication at school.

____ ____

Signature of parent or guardian Date Contact numbers (telephone/cell)

□ This med is used for emergencies only*****Additional form is required for emergency self-carry medications*****

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<u>Below must be filled out by the Doctor/Health Care Provider:</u>

Medical Diagnosis: ____

Medication: ____

Strength/Dose: ____

How often and/or at what time (hour):____

Relationship to meals, if applicable: ____

Purpose of medication: ____

Expected side effects or adverse reactions: ____

Specific indications/other information: ____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

____ ________________________

Signature of Healthcare Provider Date

____

Please print practitioner's last name Practice name Telephone

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FOR SCHOOL USE ONLY:

Date Received/By: ____________________________School Health Nurse Review: _____________________

Location of Medicine: □ on student (emergency medication only) □ in Health room □ in Classroom

AUTHORIZATION FOR EMERGENCY MEDICATION SELF-CARRY BY SOCRATES ACADEMY STUDENTS

Student's Name____ Birth date_______________

Medication(s) ____

For ____

Eligibility: Only students with asthma, diabetes and/or severe allergies who may require rescue medications (i.e., inhaler, glucagon, insulin, epi-pen, Benadryl).

_ _

Healthcare Provider: This student is judged to be capable of and has been instructed on how to self-carry and, **if applicable**, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities. In the event of an emergency, this student may need assistance by a school staff member in the administration of this medication.

Healthcare Provider Signature/Date____

Parent/Guardian: I give consent to Socrates Academy to allow my child to self-carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve Socrates Academy and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent Signature/Date ____

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared.
I will inform an adult when medication is used.

Student Signature/Date ____

School Nurse: I have received and reviewed this request.

School Nurse Initials/Date ____