Life-Threatening Allergy Information & Authorization Packet

(A new packet must be completed yearly **PRIOR** to the start of school)

Packet Contents

1. Emergency Action Plan

2. Authorization of Medication for Students During the School Day
   * requires physician and parent/guardian signature

3. Anaphylaxis Medication Self-Administration Form (if applicable)
   * requires physician and parent/guardian signature

4. Anaphylaxis Student Skills Checklist

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

_____

STUDENT NAME

SPECIAL INSTRUCTIONS REGARDING DIETARY RESTRICTIONS: _____

_____

_____

ANY SEVERE SYMPTOMS TO BE AWARE OF: _____

_____

PROTOCOL FOR MEDICATION DISPENSION:_____

_____

IF APPLICABLE: EPI-PEN INSTRUCTIONS/INHAILER INSTRUCTIONS/ANY OTHER SPECIALTY MEDICATION INSTRUCTIONS

_____

_____

_____

KNOWN DRUG ALLERGIES: _____ _____

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**

AUTHORIZATION OF MEDICATION FOR STUDENTS DURING THE SCHOOL DAY

(*Only to be filled out if medication is required during the school day*)

1. Request from a parent or guardian for permission for their child to receive medication during school hours must be accompanied by written authorization signed by the parent or guardian. A physician's signature is required on the Authorization of Medication for Students form, which details the name of the drug, dosage, and time interval for the medication, which the student is to receive. Schools may dispense only medication prescribed by a physician, and written parental permission must be obtained:

2. The medication, which has been prescribed by the physician, must be brought to school in a container appropriately labeled by the pharmacy or by the physician.

3. Medications are to be kept locked in a secure place (exceptions may be made for medicine which requires refrigeration or emergency injection). The person who has been assigned the responsibility for the security of the medication and for the delivery of the medication to the student will be an adult designated by the principal.

4. The person who has been designated by the principal to provide for the security of the medications and for the delivery of the medication to the student will maintain records of the delivery of the medication to the student as follows:

a) The date and time each dose of medication is administered to the student under the authorized agreement and the name of the drug and dosage. This is recorded on the back of the Physician's Authorization of Medication for Student form.

b) The date when the medication is discontinued.

c) Medication which is delivered only "as needed" is to be recorded each time it is given.

AUTHORIZATION OF MEDICATION FOR STUDENTS

Student's Name_____Birth Date_____

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

Medication_____

Dosage (amount to be given)_____

Relationship to meals_____

How often and at what time_____

Side effects (expected or predictable)_____

No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.

Child's parent knows of this request and is in full agreement that this medication will be supplied as needed. Should the student manifest any of the following symptoms caused by the medication, please contact the parent or my office.

Contraindications for administrations _____

_____ _____ _____

(Physician's signature) *(Telephone number)* *(Date)*

EPINEPHRINE/TWINJECT MEDICATION SELF-ADMINISTRATION FORM *(Page 1 of 2)*

Student Name: _____ Grade: _____ School Year: _____

North Carolina General Statute 115C-375.2 provides for students to carry and self-administer life-saving medications when the following criteria are met:

A licensed physician prescribed or ordered the medication for use by the child and instructed such child in the correct and responsible use of the medication.

The child has demonstrated to the child's licensed physician or the licensed physician's designee, and the school nurse, if available, the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered.

The child's physician has approved and signed a written treatment plan for managing asthma or anaphylaxis episodes of the child and for medication for use by the child. Such plan shall include a statement that the child is capable of self-administering the medication under the treatment plan.

The child's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan required in (3) above and the liability statement required in below.

The child's parent or guardian has signed a statement acknowledging that Socrates Academy and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the child or the administration of such medication by school staff. Such statement shall not be construed to release the school Academy and its employees or agents from liability for negligence.

MEDICATION NAME _____ Dose _____Time or Interval_____
Route/Inhalation device_____Instructions_____
MEDICATION NAME _____ Dose _____Time or Interval_____
Route/Inhalation device_____Instructions_____
ALLERGIES: List known allergies to medications, foods, or air-borne substances
_____
_____

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff anytime this device is used. I understand that, absent any negligence, the school shall incur no liability as a result of any injury arising from the self-administration of medication by my child.

Signature of parent or legal guardian_____

Date_____ Parent/Guardian:_____

Name: _____ Home phone: _____

Address: _____ Work and cell phones: _____

Name: _____ Home phone: _____

Address: _____Work and cell phones: _____

EPINEPHRINE/TWINJECT MEDICATION SELF-ADMINISTRATION FORM CONTINUED *(Page 2 of 2)*

I, a licensed physician or nurse practitioner, certify that this child has a medical history of severe allergic reactions, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medications(s). The child should notify school staff anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

Signature of Health Care Provider _____Date _____

Name of Health Care Provider: _____ Phone: _____Fax:_____

Address: _____

City: _____ State: _____ Zip: _____

ANAPHYLAXIS STUDENT SKILLS CHECKLIST

Epinephrine Pen Trainer Skills Checklist:

_____ Requires Supervision _____ Performs Independently

CONFIRM THAT LABEL STATES TRAINING DEVICE. Remove the gray safety cap.

1. Firmly hold the Epi-Pen with the black tip near the outer aspect of the thigh.
2. Swing and jab firmly into outer thigh and hold the Epi-Pen against the thigh for 10 seconds.
3. Remove the Epi-pen unit and massage injection area for 10 seconds.
4. Replace the gray cap.
5. You may practice again.
6. Verbalize that you will tell the supervising Socrates Academy teacher/staff member whenever you use the Epinephrine injector.

TWINJECT TRAINER SKILLS CHECKLIST:

_____ Requires Supervision _____ Performs Independently

1. Pull off green end cap, then red end cap.
2. Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.
3. Verbalize that you will tell the supervising Socrates Academy teacher/staff member whenever you use the Twinject.

SECOND DOSE ADMINISTRATION:
After you have found the appropriate personnel and if your symptoms don't improve after 10 minutes, administer second dose:

1. Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
2. Slide yellow or orange collar off plunger.
3. Put needle into thigh through skin, push plunger down all the way, and remove.

Signature of Verifying Socrates Academy Staff Member:_____

Date: _____