WESTSIDE COMMUNITY SCHOOLS

MEDICATION/HEALTH PLAN UPDATE
for
2018/19 SCHOOL YEAR

Summer 2018

Dear Parent/Guardian,

If your child has a health condition that requires an action plan and/or medication available in the health office in case of an emergency during the school year. This helps ensure that your child receives medical care as soon as an issue arises.

If your child has one of the following documented health conditions:

- Asthma requiring that an inhaler/rescue medication be kept in health office
- Severe allergy requiring EpiPen available in health office
- Allergy requiring a plan, but no EpiPen, in health office
- Seizures
- Diabetes

Helpful information when completing forms:

1. All medication must be unexpired and provided to the school by the parent/guardian in the pharmacy- or manufacturer-labeled container. Repackaged and expired medications will not be accepted

2. If an asthma/allergy plan is needed, the physician must complete the required paperwork as well as a medical authorization. This paperwork MUST be for the current school year and should have a completion date no earlier than May 2017. Please be sure that the physician documents that this is for the whole school year (through July of 2018) to ensure your child is covered all year.

3. For children who will be carrying an inhaler in their backpack or on their person, the physician must indicate that on the form. Your child will need to know how to administer the inhaler. There is another form to be completed by your child, you, and the health assistant once this is indicated. Your child will need to demonstrate proper use and what to do when s/he needs to use it.

4. If your child does not need medication at school but still has a diagnosis of one of these health conditions, we still ask that the paperwork be completed for reference on how to treat your child in case of emergency.

5. Your physician may fax this paperwork to the health office at (402) 390-2159

6. Action plan paperwork can be found on the Westside school district website under your child's school's health information tab.

These items must be completed and to the school by the first day so that we can best meet your child's medical needs. If you have questions, please contact the health office or your school nurse.

Sincerely,
School Nurse
Laurie Michael
Health Assistant:
TBA
(402) 390-6485

MEDICATION AUTHORIZATION FORM

Westside Community Schools — Office of Student Services Please PRINT Clearly

Student Last	Student First	Date of Birth	Age

School	Grade	Teacher	Allergies

PRESCRIPTION

To be completed by physician/dentist/provider

Name of Medication 1

Dosage	Route

Time of Day/Frequency

For treatment of

Emergency procedure in case of serious side effects

Is it safe for unlicensed, trained staff to provide the medication? ☐ Y ☐ N

Name of Medication 2

Dosage	Route

Time of Day/Frequency

For treatment of

Emergency procedure in case of serious side effects:

Is it safe for unlicensed, trained staff to provide the medication? ☐ Y ☐ N

I request and authorize that the above-named student be administered/ provided the above identified medication in accordance with instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Physician/Provider Signature	Date

Physician/Provider PRINTED Name	Phone Number

NON-PRESCRIPTION/OVER-THE-COUNTER

To be completed by parent/guardian

Name of Medication A

Dosage	Route

Time of Day/Frequency

For treatment of

Possible side effects

Name of Medication B

Dosage	Route

Time of Day/Frequency

For treatment of

Possible side effects:

Time frame to administer medication

Start Date	End Date (two-week maximum)

- **NO MEDICATION WILL BE GIVEN IF NOT IN ITS ORIGINAL, PROPERLY LABELED CONTAINER.**
- **If samples of medication are to be given, they must be labeled with the student's name, dosage, route, and time(s) to be given.**
- **Non-prescription medication must be labeled with the student's name.**
- **ALL MEDICATION MUST BE DELIVERED TO AND PICKED UP FROM SCHOOL BY PARENT/GUARDIAN**

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I request/authorize the school to give medication(s) to my child in accordance with the instructions above. I understand that unlicensed, trained staff may be assigned to provide medication(s) to my child, and I accept ultimate responsibility for monitoring the effects of the medication(s).

I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

In the event that the school grants my child permission to carry and self-administer medication(s), a separate, contractual agreement of responsibilities must be signed by student, parent, physician, and school official.

Parent/Guardian Signature (REQUIRED)	Date	Phone Number

Nurse Signature	Health Assistant Signature

Use additional forms for more medications

Form updated 2016

BOTH PAGES MUST BE COMPLETED AND SUBMITTED TO THE SCHOOL OFFICE

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Health Care Provider)

Student Name: _____ **Date Of Birth:** ____/____/____ (MONTH) (DAY) (YEAR)

☐ **Exercise Pre-Treatment:** Administer inhaler **(2 inhalations)** 15-30 minutes prior to exercise. (e.g., PE, recess, etc).

☐ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
☐ Albuterol DPI (ProAir RespiClick)
☐ Levalbuterol (Xopenex HFA)
☐ Use inhaler with valved holding chamber
☐ Other: _____

Asthma Treatment

Give **quick relief medication** when student has asthma symptoms, such as coughing, wheezing or tight chest.

☐ Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
☐ Albuterol DPI (ProAir RespiClick) 2 inhalations
☐ Levalbuterol (Xopenex HFA) 2 inhalations
☐ Use inhaler with valved holding chamber
☐ Albuterol inhaled **by nebulizer** (Proventil, Ventolin, AccuNeb)
☐ .63 mg/3 mL ☐ 1.25 mg/3 mL ☐ 2.5 mg/3 ml
☐ Levalbuterol inhaled **by nebulizer** (Xopenex)
☐ 0.31 mg/3 mL ☐ 0.63 mg/3 mL ☐ 1.25 mg/3 mL
☐ May carry & self-administer inhaler (MDI)
☐ Other: _____

Closely Watch the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are better, student may return to classroom **after** notifying parent/guardian
- Symptoms are not better, give the treatment again and notify parent/guardian right away
- **If student continues to get worse, CALL 911 and use the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol**

Anaphylaxis Treatment

Give **epinephrine** when student has allergy symptoms, such as hives, hard to breathe (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath).

☐ EpiPen® 0.3 mg ☐ EpiPen® Jr 0.15 mg
☐ AUVI-Q® 0.3 mg ☐ AUVI-Q® Jr. 0.15 mg
☐ Other: _____
☐ May carry & self-administer epi auto-injector
☐ **Use epinephrine auto-injector immediately upon exposure to known allergen**
☐ **If symptoms do not improve or they return, epinephrine can be repeated after 5 minutes or more**

Lay person flat on back and raise legs. If vomiting or difficulty breathing, let them lie on their side.

***CALL 911* After Giving Epinephrine & Closely Watch the Student**

- Notify parent/guardian immediately
- ***Even*** **if student gets better, the student should be watched for more signs/ symptoms of anaphylaxis in an emergency facility**
- **If student does not get better or continues to get worse, use the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol**

☐ This Student has the ability to self-manage Student's Health Condition and I authorize Student to self-manage in accordance with this Plan. If medications are self-administered, the school staff **must** be notified immediately.

Additional information: *(i.e. asthma triggers, allergens)* _____

Health Care Provider name: *(please print)* _____ **Phone:** _____

Health Care Provider signature: _____ **Date:** _____

Parent signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee: _____ **Date:** _____

BOTH PAGES MUST BE COMPLETED AND SUBMITTED TO THE SCHOOL OFFICE

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Parent/Guardian)

Student Name: _____ **Age:** _____ **Grade:** _____

School: _____ **Homeroom Teacher:** _____

Parent/Guardian: _____ **Phone(** **)** _____ **(** **)** _____

Parent//Guardian: _____ **Phone(** **)** _____ **(** **)** _____

Emergency Contact: _____ **Phone(** **)** _____ **(** **)** _____

Known Asthma Triggers: Please check the boxes to identify what can cause an asthma episode for your student.

- ❑ Exercise
- ❑ Respiratory/viral infections
- ❑ Odors/fumes/smoke
- ❑ Mold/mildew
- ❑ Pollens
- ❑ Animals/dander
- ❑ Dust/dust mites
- ❑ Grasses/trees
- ❑ Temperature/weather—humidity, cold air, etc.
- ❑ Pesticides
- ❑ Food—please list below
- ❑ Other—please list: _____

Known Allergy/Intolerance: Please check those which apply and describe what happens when your child eats or comes into contact with the allergen..

Peanuts	❑	_____
Tree Nuts	❑	_____
Fish/shellfish	❑	_____
Eggs	❑	_____
Soy	❑	_____
Wheat	❑	_____
Milk	❑	_____
Medication	❑	_____
Latex	❑	_____
Insect stings	❑	_____
Other	❑	_____

Notice: If your child has been prescribed epinephrine (such as an EpiPen®) for an allergy, you must provide epinephrine at school. If your student needs a special diet to limit or avoid foods, your doctor will need to complete the form *"Medical Statement Form to Request Special Meals and/or Accommodations" which can be found on the website—www.airenebraska.org*

Medicines: Please list medicines used at home and/or to be given at school.

Medicine Name	Amount/Dose	When does it need to be given

I understand that all medicines to be given at school must be provided by the parent/guardian.

Parent signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee: _____ **Date:** _____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____ Date of Birth _____

Parent/Guardian _____ Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Copyright 2008 Epilepsy Foundation of America, Inc.