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INFORMATION REGARDING STUDENT SELF-ADMINISTRATION OF MEDICATION AT SCHOOL OR SCHOOL RELATED ACTIVITIES FOR STUDENTS DIAGNOSED WITH ASTHMA OR A LIFE THREATEING ALLERGY

Memorandum to Parents/Legal Guardians

In the interest of enabling your child to make the most effective use of his/her medication, we provide the following information regarding student self-administration of medication at school. Students who are permitted to self-administer medication must meet the following requirements:

1. The District's Authorization for Student Self-Administration of Medication Form must be completed annually and on file at the School District.

2. The student is permitted to carry his/her medication and to self-administer the medication while in school or at a school-sponsored activity when necessary.

3. Before the student is allowed to self-administer medication at school, the parent must provide the school with an extra supply of the student's medication for use in the event that the student forgets to bring his/her medication to school on a particular day.

4. The student must agree, in writing, to the following conditions before he/she is allowed to self-administer medication at school:

   •Student will demonstrate proper use of an asthma inhaler/epinephrine auto injector to the school nurse or other school employee designated to administer medication prior to possessing and self-administering medication at school or a school related activity.

   •Student will take care to keep his/her medication in his/her possession and under his/her control at all times.

   •Student will never share his/her medication with another person.

   •If the student is found abusing his/her medication or using it improperly, the student's parent/guardian will be contacted and the student may lose the ability to self-administer his/her medication.

   •After self-administering his/her epinephrine medication, the student will contact the nurse or other designated school employee so they may contact 911 and monitor the student's condition.

   or

   •After self-administration of his/her asthma medication, if the student does not experience marked improvement in his/her condition within five minutes of self-administration, the student will see the nurse or other school employee designated to administer medication for further assessment of his/her condition.

RIDGEWOOD HIGH SCHOOL DISTRICT 234

STUDENT AGREEMENT TO COMPLY WITH THE RULES FOR SELF-ADMINISTRATION OF EPINEPHRINE MEDICATION AT SCHOOL AND AT SCHOOL RELATED ACTIVITIES

I, _____, state that I have been diagnosed with a life threatening allergy and have been prescribed epinephrine medication by a qualified health care professional. I hereby agree to comply with the following rules for self-administration of epinephrine medication:

1. I will demonstrate proper use of a prescribed epinephrine auto-injector to the school nurse or other school employee designated to administer medication prior to possessing and self-administering my medication at school.

2. I will take care to keep my epinephrine auto-injector in my possession and under my control at all times.

3. I will never share my medication with another individual.

4. After self-administering my epinephrine medication, I will immediately contact the nurse or other designated school employee so they may call 911 and monitor my condition.

I understand that if I am discovered to be abusing my epinephrine medication or using it improperly, my parent/guardian will be notified and I may lose the ability to self-administer my medication at school.

Student Signature: _____

Parent Signature: _____

Parent Signature: _____

SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT NAME_____ BIRTHDATE _____

ADDRESS_____PHONE NUMBER_____

SCHOOL_____ GRADE _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

I, _____, parent or guardian of _____, hereby authorize Ridgewood High School District 234, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of the school district, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE STUDENT'S LISCENSED PRESCRIBER (except for a student self-administering asthma medication)

Diagnosis:_____ Name of Medication:_____

Dosage:_____ Route of Administration:_____

Time/Circumstances when Medication Should be Administered: _____

Side Effects:_____

Date of Prescription: _____ Discontinuation Date: _____

***For students with diabetes, the licensed prescriber should approve and sign the student's diabetes care plan**

Self-administration of epinephrine: _____Yes _____No. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the above mentioned medication and is capable of doing this independently. The student understands the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

_____ _____ _____

Licensed Prescriber Name (Print) Signature of Licensed Prescriber Date

Address: _____Telephone: _____

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION

Self-administration of asthma medication: _____Yes _____No. I give permission for my child, _____, to carry the following medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

Diagnosis:_____ Name of Medication:_____

Dosage:_____ Route of Administration:_____

Time/Circumstances when Medication Should be Administered: _____

Side Effects:_____

Date of Prescription: _____ Discontinuation Date: _____

_____ _____

Parent/Guardian Signature Date

Dear Parent/Guardian,

Below is an explanation of the District's regulations and policies concerning the administration of medication to students during the school day or during school related activities. We firmly believe that medication should be administered at home. The administration of medication to students during regular school hours and during school related activities is strongly discouraged unless absolutely necessary for the critical well being and health of the student. Please check with your child's physician to determine if there is a way to avoid your child taking medication at school. Only medication prescribed by a licensed prescriber which is absolutely necessary to maintain the child in school will be administered. The following regulations must be complied with prior to a student receiving medication at school:

1. The student's Parent/Guardian must notify the school nurse, school health assistant or school secretary that their child must take medication while at school.

2. Prior to administering any medication at school, the parent/guardian must fill out and file at the school the required School Medication Authorization Form. (Any change in the prescription must be reported immediately and a new, revised School Medication Authorization Form submitted. The Authorization for Administration of Medication Form is only effective for the current school year and will need to be renewed each subsequent school year.

3. Medication must be brought to school by the parent/guardian in the pharmacy prescription bottle labeled with the child's name, the name of the medication, the dosage, the administration instructions and the name of the physician who prescribed the medication. Medications must be left in the school health office and not transported back and forth between home and school. At the end of the school year or at the end of the prescription, all remaining medication not administered at school must be picked up by the student' Parent/Guardian.

4. Medication will be kept in the school health office. Students are responsible for coming to the office at the time he/she is to take his/her prescribed medication. Students are not permitted to keep medication on their person or in their lockers unless authorized to possess and self-administer medication due to risk of anaphylaxis or an asthmatic condition.

5. Any medication prescribed to be taken three times a day will be given at home unless specifically ordered by the physician to be taken during school hours.

6. Non-prescription medications (i.e. Aspirin, Tylenol, Advil, cough medicine, cough drops, cold remedies, vitamins) will not be given at school unless prescribed by a physician. The same regulations and policies for administration of medication apply to non-prescription medications. Such medication must be in its original container and labeled with the child's name, dosage and administration instructions.

7. The parent/guardian of students who are authorized to possess and self-administer their asthma medication or epinephrine medication must fill out the Authorization for Student Self-Administration of Medication Form and the Student Agreement to Comply with the Rules for Self-Administration of Medication Form. Students carrying inhalers or epinephrine auto-injectors at school will be considered in violation of the medication policy without this paperwork on file.

Thank you for your cooperation with these necessary regulations. If you have any questions, please contact your school nurse or health assistant.

PLEASE COMPLETE BOTH SIDES

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's Photograph

NAME:_____ D.O.B:____/____/____

TEACHER:_____ GRADE:_____

ALLERGY TO:_____

Asthma: ◯ Yes (higher risk for a severe reaction) ◯ No

Weight: _____ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

CONTACTS: Call 911 Rescue squad: (____)_____

Parent/Guardian: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Licensed Healthcare Provider Signature:_____ Phone:_____ Date:_____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature:_____ Date:_____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name:_____ Room:_____

Name:_____ Room:_____

Name:_____ Room:_____

LOCATION OF MEDICATION

☐ Student to carry

☐ Health Office/Designated Area for Medication

☐ Other: _____

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)
414-272-6071
http://www.aaaai.org
http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf
http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital
773-KIDS-DOC
http://www.childrensmemorial.org

Food Allergy Initiative (FAI)
212-207-1974
http://www.faiusa.org

Food Allergy and Anaphylaxis Network (FAAN)
800-929-4040
http://www.foodallergy.org

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.