Joplin Public Schools
Request for Administering Medication at School

Student Name: ____________________________Grade ________Teacher _________________

It is generally recognized that some students may require medications for chronic or short-term illness during the day to enable them to remain at school and participate in their education. While parents carry the primary responsibility for their child's health, they may need to delegate some of this responsibility to school personnel who may or may not be health professionals.

Medications should be given at home whenever possible. Most medications prescribed for 3 times a day can be given before the child leaves for school, when the child gets home from school, and at bedtimes. If medications must be given during the school day, the following procedures will apply:

PRESCRIPTION MEDICATIONS:

1. Prescription medications must be accompanied by written authorization from the parent or legal guardian along with dosage and directions.
2. Medications, including inhalers, must be in the original **current** container with a prescription label containing the child's name, name of medicine, dosage and directions. **Do not send medications in envelopes, plastic wrap, lunch boxes, etc. it will not be administered.**
3. The first dose of any medication must be administered at home.
4. Medications may be administered by a school nurse, or other personnel that may not be a health professional but have completed competency training.
5. Medications, along with written authorization for medication administration, will be brought to the nurse office for review prior to administration of medications.

OVER THE COUNTER MEDICATIONS:

1. Non-prescription medicine must be in its original **current** container and be accompanied by written authorization from the parent or legal guardian along with dosage and directions. **A limit of 25 doses of each over the counter medication will be given during the school year.**
2. If it is necessary for a child to regularly take a non-prescription medication, such as for migraines or arthritis, a request from the parent AND physician must be provided.
3. School district personnel will not provide any medication at any time.
4. Without a physician's order, adult medications will not be administered to a child who does not meet the weight and/or age guidelines.
5. The district will not administer any medication that is not regulated by the U.S. Food and Drug Administration.

I consent to allow district personnel to administer the medication indicated on the back of this form to my child during school hours, which will remain in effect for the current school year. I fully understand that the Board of Education, Joplin School District, employees thereof shall not be held responsible or liable in the event of injury resulting from medication administered by district personnel. **I understand all medication not picked up by the last day of school will be discarded.** I understand no medications will be administered in any amount exceeding the recommended daily dosage listed in the current volume of the Physician's Desk Reference or other recognized medical or pharmaceutical text. **I understand all medications must be dropped off by an adult and not sent to school with students.**

PARENT/GUARDIAN SIGNATURE: ________________________________ Date: ________

*Above signature by parent/guardian to also serve as authorization to discuss medication/health with the prescribing physician.

Student Name: ____________________________ DOB: _____________ Grade/Room: ____________________

Parent/Guardian contact number: __________________________________

Medication name and strength	Exact Dosage	Time(s) to be given	Prescribing Physician	RX#	Begin Date
For Treatment of	Amount left	Special Instructions (refrigerate, spacer, etc)		Expiration Date	End date

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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Jun																															
Jul																															

Signature	Initial	Signature	Initial

CODES:	Additional Inventory/Notation:____
A-Absent D-Early Dismissal DC-Discontinued F-Field Trip N-None Available O-No Show NS-No School PG-Parent Gave R-Refused W-Withheld H-Holiday --Weekend *See Nurse Note	____ ____ ____ ____ ____ ____ ____ ____

My Seizure Response Plan

Name: ______________________ Birth Date: ______________

Address: ______________________ Phone: ______________

1st Emergency Contact /Relation: ______________________ Phone: ______________

2nd Emergency Contact / Relation: ______________________ Phone: ______________

Seizure Information

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

____

____

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: ______________ Model: __________ Serial# __________ Date Implanted ______________

Dietary Therapy: ______________________ Date Begun: ______________

Special Instructions: ______________________

____

Other Therapy: ______________________

____

continued on back

Seizure First Aid

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed: ____________________

Call 911 if...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed: ____________________

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: ____________________ Phone: ____________________

Nurse/Other Health Care Provider: ____________________ Phone: ____________________

Preferred Hospital: ____________________ Phone: ____________________

Primary Care: ____________________ Phone: ____________________

Pharmacy: ____________________ Phone: ____________________

Special Instructions: ____________________

My signature ____________________ Date ____________________

Provider signature ____________________ Date ____________________

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SCHOOL SEIZURE ACTION PLAN FOR

________________________ (INSERT NAME HERE)

Attach Student Photo

ABOUT

Name ________________________ Date of Birth ____________

Doctors Name ________________________ Phone ____________

Emergency Contact Name ________________________ Phone ____________

Emergency Contact Name ________________________ Phone ____________

Seizure Type/Name: ________________________

What Happens: ________________________

How Long It Lasts: ________________________

How Often: ________________________

Seizure Triggers:

- ☐ Missed Medicine
- ☐ Emotional Stress
- ☐ Alcohol/Drugs
- ☐ Menstrual Cycle
- ☐ Missing meals
- ☐ Lack of Sleep
- ☐ Physical Stress
- ☐ Flashing Lights
- ☐ Illness with high fever
- ☐ Response to specific food, or excess caffeine Specify: ____________
- ☐ Other Specify: ____________

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often/When
Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)		

CAUTION–STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

- ☐ Headache
- ☐ Staring Spells
- ☐ Confusion
- ☐ Dizziness
- ☐ Change in Vision/Auras
- ☐ Sudden Feeling of Fear or Anxiety
- ☐ Other Specify: ____________

Additional Treatment:

☐ Continue Daily Treatment Plan

- If missed medicine, give prescribed dose from above ASAP.
- Do not give a double dose or give meds closer than 6 hours apart.

☐ Change to: ____________ How Much: ____________ How Often/When: ____________

☐ Add: ____________ How Much: ____________ How Often/When: ____________

☐ Other Treatments/Care: (i.e.: sleep, devices): ________________________

SCHOOL SEIZURE ACTION PLAN

DANGER – GET HELP NOW

Follow Seizure First Aid Below

☐ Contact School Nurse or Adult trained on rescue medication:

Name: ______________ Number: ______________

☐ Record Duration and time of each seizure(s)

☐ Call 911 if:

- Student has a convulsive seizures lasting more than ___ minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

☐ Rescue therapy provided according to physician's order:

____

____

POST SEIZURE RECOVERY

Typical Behaviors / Needs After Seizure:

☐ Headache ☐ Drowsiness / Sleep ☐ Nausea ☐ Aggression ☐ Confusion / Wandering ☐ Blank Staring

☐ Other Specify: ______________

Reviewed / Approved by:

____

Physician Signature Date

____

Parent / Guardian Signature Date

SEIZURE FIRST AID

Image adapted with permission from the Epilepsy Foundation of America

LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

childneurologyfoundation.org/sudep

dannydid.org

EPILEPSY FOUNDATION
SUDEP INSTITUTE

epilepsy.com/sudep-institute

Joplin School District

ALLERGY ACTION PLAN

Student Name:	Date of Birth:	Student #:
Health Care Provider/Title:	Provider's Phone/Fax:	
Parent/Guardian:	Parent/Guardian Phone:	
Emergency Contact:	Emergency Contact Phone:	
Emergency Contact:	Emergency Contact Phone:	

HEALTHCARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

ALLERGY TO: ____

☐ If checked, give ANTIHISTAMINE immediately if the allergen was *likely* eaten or contacted, even if no symptoms are noted.

☐ If checked, give EPINEPHRINE immediately for ANY symptoms if the allergen was *likely* eaten or contacted.

☐ If checked, give EPHINEPHRINE immediately if the allergen was *definitely* eaten or contacted, even if no symptoms are noted

MEDICATION ORDER (circle dose)

☐Epinephrine: 0.15 mg 0.3 mg

Antihistamine:

☐Diphenhydramine: 12.5mg 25mg 50mg

OR

☐Other: ______________________________

ASTHMA:

☐Yes (higher risk for severe reaction)

☐No

Additional Information:

MEDICATION MUST ACCOMPANY THE STUDENT WHEN HE/SHE IS OFF SCHOOL GROUNDS (I.E., FIELD TRIP)

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

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 and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body area

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

➔

1. **INJECT EPINEPHRINE IMMEDIATELY** (note time administered)
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications as ordered:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

➔

1. **GIVE ANTIHISTAMINE** (per order above)
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Monitoring:

- **Stay with student!** Alert parent/guardian and healthcare provider (treat student even if parents cannot be reached).
  - If cannot reach parent/guardian, try other emergency contacts listed above.
- Tell rescue squad epinephrine was given and additional epinephrine may be needed.
- For a severe reaction, consider keeping student lying on back with legs raised.

PARENT/GUARDIAN CONSENT:

I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that needs to know at school.

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

SCHOOL NURSE SIGNATURE: ______________________________ **DATE:** ______________

Date Epinephrine received: ______________ Medication expiration date: ______________

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone
Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): ____________________

____

Controller Medicine(s) Given in School: ____________________

Rescue Medicine: Albuterol/Levalbuterol ________ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol ________ puffs 15 minutes before activity as needed

😐 Yellow Zone
Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol ________ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: ____________________

☐ Add: ____________________

____

☐ Change: ____________________

If the child is in the yellow zone more than 24 hours or is getting worse, follow red zone and call the doctor right away!

☹ Red Zone
If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.

Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol ________ puffs every ____________

Take: ____________________

____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as “given in school” in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

BEE-STING ALLERGY ACTION PLAN

This child's record indicated that he/she has a bee sting allergy.

Student's Name: ______________________ Grade/ Rm #__________
Parent/Guardian's Name: ______________________________________
Mother: (Home) __________(Cell) __________(Work)__________
Father: (Home) __________(Cell) __________ (Work) __________

Symptoms of student's allergic response (Check all that apply):

_____ Hives, itchy rash, swelling of face or extremities
_____ Swelling at site (describe) ______________________________
_____ Severe pain at site of sting
_____ Itching, tingling, or swelling of lips, tongue, mouth
_____ Red, itchy, watery eyes
_____ Shortness of breath, repetitive coughing, wheezing
_____ Other (describe) ______________________________

ROUTINE BEE-STING PROCEDURE

- Notify parent/guardian immediately.
- If stinger is present, scrape off with index card.
- Clean area with soap and water
- Apply ice to the sting area
- Observe for 10 minutes for an allergic reaction

EMERGENCY BEE STING PROCEDURE

(Please check for the appropriate treatment)

_____ Use the above Routine Bee-Sting Procedure ONLY.

_____ Use the above Routine Bee-Sting Procedure AND give Benadryl.
If the child is to have Benadryl, please send in the original container with a completed medication form.

_____ Use the Routine Bee-Sting Procedure AND use the Epi-Pen.
If the child is to have an Epi-Pen injection, please send the Epi-Pen and a completed medication form. 911 WILL BE CALLED IF EPI-PEN IS GIVEN

Special Instructions: ____
____
____

I authorize the school personnel to follow this plan. I will provide the medication and Dr's order as needed for this plan. ______________________________
Parent Signature

Date of Plan: _______________

Diabetes Medical Management Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Effective Dates: ____

Student's Name: ____

Date of Birth: _______________________ Date of Diabetes Diagnosis: __________________

Grade: ______________________________ Homeroom Teacher: _______________________

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

Mother/Guardian: ____

Address: ____

____

Telephone: Home __________________ Work _________________ Cell_________________

Father/Guardian: ____

Address: ____

____

Telephone: Home _________________ Work __________________ Cell _________________

Student's Doctor/Health Care Provider:

Name: ____

Address: ____

Telephone: ________________________ Emergency Number: __________________________

Other Emergency Contacts:

Name: ____

Relationship: ____

Telephone: Home _________________ Work _________________ Cell __________________

Notify parents/guardian or emergency contact in the following situations: __________________

____

____

Blood Glucose Monitoring

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other ___________________

Usual times to check blood glucose ____

Times to do extra blood glucose checks (*check all that apply*)

☐ before exercise

☐ after exercise

☐ when student exhibits symptoms of hyperglycemia

☐ when student exhibits symptoms of hypoglycemia

☐ other (explain): ____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: ____

____

Type of blood glucose meter student uses: ____

____

Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood glucose levels. ☐ Yes ☐ No

Correction Dose (sliding scale method)

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

Correction Dose (correction factor method)

Correct blood glucose greater than____ mg/dl Correction factor _____

Target blood sugar for correction _____

Can student give own injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw correct dose of insulin? ☐ Yes ☐ No

_______ Parents are authorized to adjust the insulin dosage under the following circumstances:
____

____

For Students with Insulin Pumps

Type of pump: ______________________ Basal rates: _____ 12 am to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in pump: ____

Type of infusion set: ____

Insulin/carbohydrate ratio: _______________________ Correction factor: _______________

Student Pump Abilities/Skills:	*Needs Assistance*	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

For Students Taking Oral Diabetes Medications

Type of medication: __________________________________ Timing: _______________

Other medications: __________________________________ Timing: _______________

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	*Time*	*Food content/amount*
Breakfast	______________________	__________________________________
Mid-morning snack	______________________	__________________________________
Lunch	______________________	__________________________________
Mid-afternoon snack	______________________	__________________________________

Dinner ________________________ ______________________________________

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount:

____

Preferred snack foods:

____

Foods to avoid, if any:

____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): ____

____

Exercise and Sports

A fast-acting carbohydrate such as ____ should be available at the site of exercise or sports.

Restrictions on activity, if any: ____ student should not exercise if blood glucose level is below ____________________ mg/dl or above ____________________ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: ____

____

Treatment of hypoglycemia:____

____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _______, Dosage _______, site for glucagon injection: _______arm, _______thigh, _______other.

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: ____

____

Treatment of hyperglycemia: ____

____

Urine should be checked for ketones when blood glucose levels are above _________ mg/dl.

Treatment for ketones: ____
____

Supplies to be Kept at School

_______Blood glucose meter, blood glucose test strips, batteries for meter

_______ Lancet device, lancets, gloves, etc.

_______Urine ketone strips

_______Insulin pump and supplies

_______Insulin pen, pen needles, insulin cartridges

_______Fast-acting source of glucose

_______Carbohydrate containing snack

_______Glucagon emergency kit

Signatures

This Diabetes Medical Management Plan has been approved by:

____ ______________________

Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____________________________ school to perform and carry out the diabetes care tasks as outlined by ________________________'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

____ ______________________

Student's Parent/Guardian Date

____ ______________________

Student's Parent/Guardian Date