Every Child ~ Every Day

AUTHORIZATION TO GIVE MEDICATION

If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this Form must be completed and filed with the School Clinic.

STUDENT'S NAME: _____

TEACHER: _____ **GRADE:** _____

I authorize St. Benedict's Episcopal School to assist my child in taking this medication. I understand that:

- Medications must be in the original labeled container. Pharmacists may provide two labeled bottles for this purpose. Medications sent in an unlabeled container will not be given. If your child takes daily medication, please send an extra bottle to be used for field trips and After School Program.
- Written permission of the parent/guardian is required for the administration of all medications.
- The parent/guardian must inform the school of any medication changes. New medication or new doses will not be given unless a new form is completed.
- Medications must be brought to the office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued. If medication is given throughout the school year, medication will be disposed of according to the medication Rule Section IX.

NAME OF MEDICATION: _____

DOSE: _____ ROUTE*: _____ TIME(S) to be given: _____

DATE TO DISCONTINUE MEDICATION: _____

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

Licensed Health Care Provider: _____

Licensed Health Care Provider's Phone: _____

I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse St. Benedict's Episcopal School, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request.

_____ _____

Parent/Guardian Signature Date

Home Phone: _____ **Work Phone:** _____ **Pager/ Cell Phone:** _____

*Route: The method that medication is administered, such as by mouth, injection, inhaler, rectum, etc.

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ____/____/____

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

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

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

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 areas:

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

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -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
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

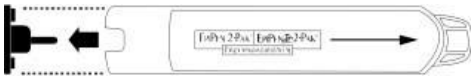
_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

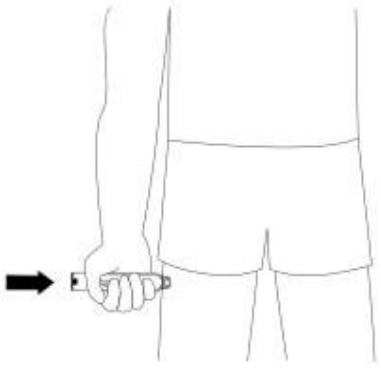
TURN FORM OVER **Form provided courtesy of Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013**

EpiPen® (epinephrine) Auto-Injector Directions

- **First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**



- **Hold orange tip near outer thigh (always apply to thigh)**



- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.**

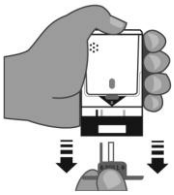
Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

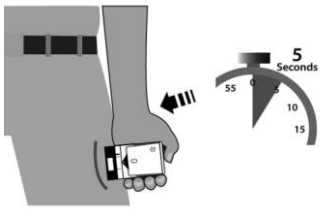
EPIPEN 2-PAK® EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard.





Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 • Rescue squad: (____)_____-_____Doctor: _____ Phone: (____)_____-_____
Parent/Guardian: _____ Phone: (____)_____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (____)_____-_____
Name/Relationship: _____ Phone: (____)_____-_____

Form provided courtesy of the Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013

I want to be able to: _____

_____

Children's℠
Healthcare of Atlanta
Dedicated to All Better

My asthma action plan

Patient name: _____ DOB: _____

Doctor's name: _____ Signature: _____

Doctor's phone #: _____ Date: _____

Controller medicines	How much to take	How often	Other instructions
		_____ times per day **EVERY DAY**	❑ Gargle or rinse mouth after use
		_____ times per day **EVERY DAY**	
		_____ times per day **EVERY DAY**	

Quick-relief medicines	How much to take	How often	Other instructions
	❑ 2 puffs ❑ 4-6 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	**NOTE: If you need this medicine more than 2 days a week, call your doctor.**

Asthma triggers (check all that apply):

❑ Exercise ❑ Change in temperature ❑ Molds ❑ Animals ❑ Strong odors or fumes ❑ Smoke
❑ Pollens ❑ Respiratory infections ❑ Dust ❑ Strong emotions ❑ Food/Other_____

Special instructions when I am — *Doing well* — *Be careful* — *Ask for help*

GREEN ZONE

Doing *well.*

- No coughing, wheezing, chest tightness, shortness of breath during the day or night
- Can go to school and play

PREVENT asthma symptoms every day:

- ☐ Take my controller medicines (above) every day
- ☐ Before exercise, take _____ puff(s) of _____
- ☐ Avoid triggers that make my asthma worse (See above)

YELLOW ZONE

Be *careful.*

- Coughing, wheezing, chest tightness, shortness of breath
- Waking at night due to asthma symptoms
- Can do some, but not all, usual activities
- Runny nose, watery eyes

CAUTION. Continue taking my controller medicines every day.

- ☐ Take _____ puffs or _____ nebulizer treatment(s) of quick relief medicine. If I am not back in the ***Green Zone*** within one hour, then I should:
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____ days.
- ☐ Increase _____
- ☐ Add _____

RED ZONE

Ask for *help.*

- Very short of breath
- Continual coughing
- Skin between ribs is pulling inwards
- Difficulty speaking without running out of breath
- Quick-relief medicines have not helped
- Symptoms same or worse after 48 hours in Yellow Zone

MEDICAL ALERT! Get help!

- ☐ Take quick-relief medicine:_____ puffs every _____ minutes and get help immediately.
- ☐ Take _____
- ☐ Call _____

If skin, fingernail or lip color is blue at any time:

Call 911 for help or go to the nearest Emergency Department

Always consult your child's doctor or other healthcare provider if you have any questions or concerns about the care or health of your child.
Children's Healthcare of Atlanta at Hughes Spalding is owned by Grady Health System® and managed by HSOC, Inc. an affiliate of Children's.

Children's Healthcare of Atlanta

Children's Pediatric Neurology Practice
404-785-KIDS (5437)

SEIZURE ACTION PLAN

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 Provider: Phone:

Significant Medical History:

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Emergency Medications

Medication	Dosage	Common Side Effects & Special Instructions

Green Zone Less than 2 minutes	Yellow Zone 2 to 5 minutes	Red Zone More than 5 minutes or 3 or more seizures in an hour
✱ Begin seizure First Aid ✱ Closely observe student until recovered from seizure ✱ Notify parent/guardian ✱ Return student to class	✱ Continue Seizure First Aid ✱ Call for help ✱ Prepare to administer Diastat/Versed ✱ Closely observe student until recovered ✱ Notify parent/guardian ✱ Student may return to class/home as instructed by parent/guardian	✱ Continue Seizure First Aid ✱ Administer Diastat/Versed ✱ Monitor respirations and heart beat and start CPR if needed ✱ Notify parent/guardian ✱ Call 911 if seizure is greater than 7 minutes

Basic Seizure First Aid

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

For tonic-clonic seizure:

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

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

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

Describe any special considerations or precautions:

Provider Signature Date Time

Parent/Guardian Signature Date Time