As Needed Medical Forms

Dear Parents,

Attached are some commonly used medication forms that your child may need. These forms are to be completed annually except for the School Entrance Physical Examination. Please be aware that most forms require a parent and licensed health care provider signature. Once the form is complete turn it in to your preschool director or classroom teacher.

Our fax number is (440) 237-3308 Attn: School Clinic

If you have any questions call the clinic at (440) 237-9247

Page 1: Medication Administration Form

Pages 2,3: Asthma Action Plan

Pages 4,5: Allergy Action Plan (food allergies/bee-stings)

Page 6: Immunization Exemption Form

Page 7: 6th Grade Tdap Booster and Meningococcal Vaccines

Page 8: School Entrance Physical Examination (1st time enroll only)

PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

***** One Medication per Form *****

Student Photo

School ______________________________

Student ______________________________ Grade/Rm______

Address ______________________________

City/State/Zip ______________________________

Name of Medication and Dosage ______________________________

Times of Day to be Administered______________________________

Number of Times/Intervals Medication is to be Administered______________________________

Date to Begin Medication__________________ Date to End Medication__________________

Adverse/Severe Reaction that Should be Reported to Physician ______________________________

Special Instructions for Administration of Medication______________________________

This medication can be safely administered by non-medical personnel ☐ Yes No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours ☐ Yes No

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

______________________________ ______________
Prescriber's Printed Name Tel

______________________________ ______________
Prescriber's Signature Date

Please regard my signature below as my assurance that I release ______________________________ ______________________________School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

______________________________ ______________
Parent's Printed Name Tel

______________________________ ______________
Parent's Signature Date

ASTHMA ACTION PLAN

Student Photo

Student Information:

Student: ______________________ Birthdate: __________

School: ______________________ Grade/Rm. __________

Emergency Information:

Parent(s) or Guardian(s) ______________________

Mother: Tel (W) __________ Tel (H) __________

Father: Tel (W) __________ Tel (H) __________

Healthcare Provider __________ Tel __________

In case of emergency, contact:

1. Name __________ Tel __________
2. Name __________ Tel __________

Asthma Emergency Action:

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Call 911.
- Call Parent/Guardian and/or Healthcare Provider

Triggers: ______________________

Name of Medication	Dosage	Time

Start Date __________ End Date __________

Steps for an Acute Asthma Episode (to be completed by physician)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Signature of Parent/Guardian ______________________ **Date** __________

Signature of Prescriber ______________________ **Date** __________

PLEASE COMPLETE NEXT PAGE FOR PERMISSION TO CARRY INHALER

************SELF-MEDICATION FOR ASTHMA INHALERS************* Authorization

(In accordance with ORC 3313.716/3313.14)

☐ **Please check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF- MEDICATE at school.**

Complete the following and parent/guardian and healthcare provider must SIGN below:

Student Name ______________________________

Medication ______________________________

Dosage/Time(frequency) ______________________________

Date to Begin Administration ______________________ Date to End Administration ______________________

Adverse reactions that should be reported to physician:

Adverse reactions for unauthorized user:

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

Other special instructions:

Prescriber and Parent/Guardian Names and Signatures REQUIRED for Self Medication of Asthma Inhalers:

Prescriber Name ______________________ Tel ______________________

Signature of Prescriber ______________________ Date ______________________

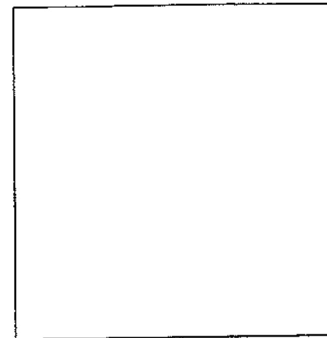
Parent/Guardian Name(s) ______________________ Tel ______________________

Signature of Parent/Guardian ______________________ Date ______________________

Copies must be provided to the principal and to the nurse.

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN



Student ______________________ School ______________________.
DOB ______________________ Teacher/Grade ______________________
Allergy to ____
Asthmatic? ☐ Yes* ☐ No *Higher risk for severe reaction

STEP 1 - TREATMENT

SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

The severity of symptoms can quickly change. †Potentially life threatening.

Symptoms		**Give checked Medication****
		***To be determined by physician authorizing treatment*
♦ If a student has been exposed to/ingested an allergen but has NO symptoms:		☐ Epinephrine ☐ Antihistamine
♦ Mouth	Itching, tingling, or swelling of lips, tongue, mouth:	☐ Epinephrine ☐ Antihistamine
♦ Skin	Hives, itchy rash, swelling of the face or extremities:	☐ Epinephrine ☐ Antihistamine
♦ Gut	Nausea, abdominal cramps, vomiting, diarrhea:	☐ Epinephrine ☐ Antihistamine
♦ Throat†	Tightening of throat, hoarseness, hacking cough:	☐ Epinephrine ☐ Antihistamine
♦ Lung†	Shortness of breath, repetitive coughing, wheezing:	☐ Epinephrine ☐ Antihistamine
♦ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness:	☐ Epinephrine ☐ Antihistamine
♦ Other†	______________________:	☐ Epinephrine ☐ Antihistamine
♦ If reaction is progressing, (several of the above areas affected), give:		☐ Epinephrine ☐ Antihistamine

<u>MEDICATION:</u> START DATE ______________________ END DATE ______________________

Epinephrine: Inject intramuscularly.

Important; *Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.*

☐ Epinephrine Autoinjector **0.3mg**

☐ Epinephrine Autoinjector **0.15mg**

Antihistamine: Give ____
antihistamine/dose/route

Other: Give ____
medication/dose/route

Parent/Guardian Signature ______________________ **Date** ______________
Prescriber Name ______________________ **Phone** ______________
Prescriber Signature ______________________ **Date** ______________

STEP 2 - EMERGENCY CALLS

PARAMEDICS (911) MUST BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN. EPIPEN OR AUVI-Q ONLY LAST 15-20 MINUTES.

Call 911. State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Auvi-Q) and that additional epinephrine may be needed. Always send empty autoinjector to ER with student. Contact Parent/Guardian.

EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, DO NOT HESITATE TO MEDICATE CHILD & CALL 911

EMERGENCY CONTACTS

Name	Relationship	Telephone number
1.		
2.		

****** Form on Page 2 to be completed ONLY if student will be carrying an Epinephrine Autoinjector ******

Proprietary information of PSI Affiliates, Inc. May not be copied without consent.

******(To be completed ONLY if student will be carrying an Epinephrine Autoinjector)******

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with ORC 3313.718/8313.141)

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is not prescribed who receives a dose

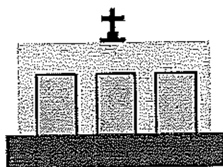
Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07



SAINT ALBERT THE GREAT CATHOLIC SCHOOL

Dear Parent,

Please read and sign the following form and return it to the school nurse at Saint Albert the Great as soon as possible. You can fax it to 440-237-3308 or email it to clinic@saint-albert.org. If a student is exempt from any immunization, for any reason, this form must be filled out yearly and signed. If you have any questions, you may contact the school nurse at 440-237-9247.

STATE OF OHIO LEGAL IMMUNIZATION EXEMPTION

Per OHIO STATUTE 3313.671 (Exemptions) Religious, Good Cause, and Medical Exemption Form Amended Substitute Senate Bill No. 282. Ohio Revised Code. Sections 3313.671. Pat (3) and (4) I understand that the immunization Law permits me to sign a waiver on my child taking the immunization. I hereby object and request the school to waiver the immunization of my child against the following:

(You must circle which vaccine the child is exempt from)

DtaP	MMR	Polio	HIB	Other: Please write in
Tdap	Influenza	Hepatitis B	Meningococcal (7th grade and up)	
Td (7th grade and up)	Varicella	Hepatitis A	Pneumococcal	

Child's name: ______________________________ Religious affiliation: ________________

Good Cause: ____

____

Medical Reason: You must have a signed statement from your physician stating the condition and attach it to this form.

I further understand that during the course of an outbreak of any of the aforementioned vaccine preventable diseases, that the student named here is subject to exclusion from school for the aforementioned vaccine preventable diseases, for the duration of the outbreak. This action is necessary not only to protect this student, but the remainder of the students and faculty of the school.

Parent Signature: ____________________________________ Date ________________

Address: ____

"Our mission is to work with families, to educate each child, to know, believe, and live the Catholic faith and to continue life-long learning."

Letter to 6th Grade Parents/Guardians
Tdap Booster & Meningococcal Vaccine

TO: Parents/Guardians

FROM: School Health Clinic

DATE: ______________

SUBJECT: Tdap Booster & Meningococcal Vaccine

Dear Parents/Guardians,

Beginning with the 2016-2017 school year, the Ohio Department of Health School Immunization Requirements have been revised to include one dose of Meningococcal (MCV4) vaccine to be administered before a student enters the seventh grade. Therefore, your current sixth grader will need to show proof of having received the Meningococcal (MCV4) vaccine before they can return to school in the fall.

Your child also requires a dose of Tdap to be administered before a student enters the seventh grade. This dose is intended to be administered as a booster dose for students who have completed the required doses of the initial series of DTaP/DT/Td. Therefore, your current sixth grader will need to show proof of having received this booster dose before they can return to school in the fall.

If your child received one dose of Tdap as part of the original series, another dose of Tdap will not be required. The Tdap can be given regardless of the interval since the last tetanus or diptheria-toxoid containing vaccine.

You are receiving this letter now to provide you with ample time to have your child immunized before the coming school year begins. Please contact your physician or health department to schedule an appointment.

Please provide the date that your child received the vaccines.

____
(Name)

received the Meningococcal (MCV4) vaccine on ______________________________.
(Date)

received the Tdap vaccine on ______________________________.
(Date)

____
Signature

SAINT ALBERT THE GREAT SCHOOL

School Entrance Physical Examination

Name: ______________________ Birth Date: __________ Grade: ______________

Immunization Information

Please **complete the entire date** including month, day and year:

DTP/Dtap: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

Td/Tdap: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

OPV/IPV: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

HIB: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

Hepatitis B: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

MMR: 1. ________ 2. ________ **Hepatitis A:** 1. ________ 2. ________

Other: 1. ________________ **Varicella Vaccine** 1. ________ 2. ________

Height: ____________ Weight: ____________ Blood Pressure ____________

Examination: Date ______________ Normal__________ Abnormal __________

Remarks and recommendations concerning abnormal findings:______________________

____

Restrictions: ________________ Development: Normal________ Abnormal__________

Chronic Health Concerns: Asthma: __ Seizure Disorder: ___ ADD/ADHD: ___ Diabetes: _____

Other: ______________________________________

Medications:

Name of medication/ dosage/frequency:______________________________

Reason for medication: ______________________________________

Please complete form for medication administration if it is necessary for the child to receive prescription or OTC medication in school.

Was child referred to a specialist for any reason? Explain ______________________

____

Special Tests (at discretion of physician)

Urinalysis ______________________ Hemoglobin ______________________

Lead ______________________ Sickle Cell ______________________

Tuberculin test: (most recent) Date:________Type: _______ Results: Positive_____Negative _____

Other:____

Hearing: Type of test:________________Results:______________Comments: ______________

Vision: Acuity: Right – 20/__ Left – 20/__ Strabismus: Yes No Comments: __________

____

Physician Name (Print): ______________________________ Phone: ______________

Address: ______________________________ City/ state/ zip ______________________

Based on examination consistent with EPSDT/Headstart/ AAP guidelines, I certify this child to be in a suitable condition for enrollment in school.

Physician Signature: ______________________________ Date: ______________