Cleveland Heights-University Heights City School District
Department of Student Services

PERMISSION FORM FOR PRESCRIBED MEDICATION

School: _____

Date form received by the school: _____

Student: _____ Birthdate: _____

Grade: _____ Teacher _____

To be completed by the physician or authorized prescriber

Reason for medication: _____

Name of medication: _____

Form of medication / treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

_____

START: ☐ when form received ☐ Other date: _____

STOP: ☐ end of school year ☐ Other date/duration: _____

☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes, Please describe: _____

_____

Special storage requirements: ☐ None anticipated ☐ Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes - Supervised ☐ Yes - Unsupervised

This student may carry this medication: ☐ Yes ☐ No

Please indicate if you have provided additional information:

☐ On the back of this form ☐ As an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (name of child) _____ to receive the above medication at school according to standard policy. The medication must be brought to school daily in the original container from the pharmacy and must contain only a single daily dosage.

Date: _____ Signature: _____ Relationship: _____

CLEVELAND HEIGHTS – UNIVERSITY HEIGHTS CITY SCHOOLS
DEPARTMENT OF STUDENT SERVICES / SCHOOL HEALTH SERVICES

ASTHMA ACTION PLAN

Student _____ D.O.B. _____ ID# _____
School _____ Grade _____ HR _____ P.E. _____

SYMPTOMS can include:
- ☐ "Tightness" in chest
- ☐ Shortness of breath
- ☐ Coughing
- ☐ Wheezing
- ☐ Breathing hard and fast
- ☐ Nasal flaring
- ☐ Other _____

TRIGGERS may include:
- ☐ Dust, molds, pollens
- ☐ Food allergies
- ☐ Animals
- ☐ Temperature changes
- ☐ Dust mites
- ☐ Strong odors, fumes, or perfumes
- ☐ Exercise
- ☐ Upper respiratory infections
- ☐ Other _____

At the FIRST SIGNS of these symptoms, DO:
1. Have the student ESCORTED to the nurse's office if the symptoms occur at school.
2. Restrict physical activity and allow the student to rest.
3. Encourage the student to breathe slowly and relax.
4. Assist student to measure Peak Flow if physician's orders direct doing so.
5. Supervise administration of medication per physician's orders (separate physician order form MUST be on file in the nurse's office.)
6. If no improvement occurs in 15-20 minutes, contact parent.
7. If relative/guardian cannot be located and asthma is not improving, call 911.
8. Other _____

To REDUCE incidents:
1. Eliminate irritants and avoid triggers in the environment.
2. Be alert to EARLY signs of respiratory distress.
3. Other _____

List **ALL** current medications

Given at **SCHOOL** (if any)		
Medication	Dose	Time

Given at **HOME** (if any)		
Medication	Dose	Time

EMERGENCY PHONE NUMBERS:
Parent/Guardian name: _____ Day #(s) _____
Other: _____ Day #(s) _____
Permission is given for the nurse to contact the following health care provider in the event emergency contacts cannot be reached or for urgent health care information:

Physician: _____ Office # _____

Parent's signature _____ Date _____

Student's signature: _____ Date: _____

School Nurse _____ Date _____

Rev.11/04

CLEVELAND HEIGHTS-UNIVERSITY HEIGHTS CITY SCHOOLS
DEPARTMENT OF STUDENT SERVICES / SCHOOL HEALTH SERVICES

ALLERGY ACTION PLAN and MEDICATION ORDER(S)

School Year ______

Asthma: ☐ No ☐ **Yes - High risk for severe reaction**

Student ______ D.O.B. ______ I.D.# ______ School ______

Grade ______ H.R. ______ **ALLERGIC TO:** ______

PHYSICIAN SECTION

◆**STEP 1: ASSESSMENT AND TREATMENT**◆

Symptoms:

Give Checked Medication as ordered below, by authorizing physician

• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• Throat ⮝	Tightening of throat, hoarseness, hacking cough	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• Lung ⮝	Shortness of breath, repetitive coughing, wheezing	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• Heart ⮝	Thready pulse, low blood pressure, fainting, pale, blueness	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• Other ⮝	______	☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• If reaction is progressing (several of the above areas affected), give:		☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______
• NO SYMPTOMS but allergen ingested or contacted (food, insect sting, molds, etc.)		☐ **Epinephrine** ☐ **Antihistamine** ☐ **None** ☐ **Other** ______

⮝ Potentially **life-threatening**. *The severity of symptoms can quickly change.*

At the FIRST SIGNS of non-life threatening symptoms, have the student ESCORTED to the nurse's office – **never send alone!** Notify office immediately if student exposed.

MEDICATION DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3mg Twinject™ 0.15mg

Antihistamine: Give ______
Medication / Dose / Route

Other: Give ______
Medication / Dose / Route

Start date: ______ **Stop date:** ______ (end of school year unless earlier date specified) **Date order received at school:** ______

Warning signs of a bad reaction to medication: ______

This student may carry this medication: ☐ **No** ☐ **Yes**

This student is capable and responsible for self-administering this/these medication(s) and has been taught proper self-administration:
☐ **No** ☐ **Yes, supervised** ☐ **Yes, unsupervised**

Do not hesitate to medicate if exposure is suspected.

Doctor's Signature ______ Date: ______

Address ______ Phone: ______ Fax: ______

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CANNOT BE DEPENDED ON TO REPLACE EPINEPHRINE IN ANAPHYLAXIS.

Allergy REV HAP-Med order5-13-08

PARENT/GUARDIAN SECTION

◆STEP 2: EMERGENCY CALLS◆

1. Call **911**. If epinephrine has been used, state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. **Dr.** _____ **Phone** _____
3. **Parents** _____ **Phone(s)** _____, _____
4. **Additional Emergency Contacts:**
   Name/relationship **Phone(s)**
   a. _____ 1) _____, 2) _____
   b. _____ 1) _____, 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY! This plan is to be used this school year with my child. I will provide the medication(s) specified as well as authorize their use. I also authorize the nurse to contact ou doctor for clarification or need.

Parent/Guardian Signature _____ Date _____
(Required)

SCHOOL SECTION

TRAINED STAFF MEMBERS

1. _____ Room _____	4. _____ Room _____
2. _____ Room _____	5. _____ Room _____
3. _____ Room _____	6. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

ADMINISTRATION

- ☐ **Pull off gray activation cap.**
  - ☐ **Hold black tip near outer thigh (always apply to thigh).**
  - ☐ **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

FIRST DOSE ADMINISTRATION

- ☐ **Remove caps labeled "1" and "2."**
- ☐ **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- ☐ **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**
- ☐ **Slide yellow collar off plunger.**
- ☐ **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

School Nurse Signature _____ Date _____

**Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission. June/2007