Wynne Public Schools

P.O. Box 69
Wynne, Arkansas 72396

Allergy Care In The School

Date_____

Student_____ Grade_____

Dear Parent/Guardian,

Our records indicated that your child has an allergy to the following:

If he/she were to have a reaction at school, we do not have emergency medicine to give him/her. If it is necessary to have Benadryl or epinephrine for his/her allergy, please bring to school with all completed paper work. If your child no longer has a problem with this allergy, please sign and return this form.

Content of packet to be completed and returned to school if emergency medication is needed:

1. Medication Administration Consent form- Parent completes
2. Allergy Action plan-**Doctor** completes- Parent signs
3. Consent to communicate with your child's doctor- Parent signs
4. Epipen self-administration consent form (not included in Primary or Intermediate school packet- please discuss with nurse if needed)-completed by **Doctor**, parent, student, and Nurse.

____MY child ONLY has a history of this allergy and no longer needs emergency medication.

Parent/Guardian:_____ Date:_____

If you have any questions, please call me at the number below. Your doctor may fax completed, signed forms to the school.

Thank you,

School Nurse

District Nurse	Primary	Intermediate	Jr. High	Sr. High
Jessie Bouland, RN	Erin Oguin, RN	Christine Flahrity, RN	Rebecca Strasser, RN	Lindsay Marotti, RN
(870) 238- 5030	238-5050 ext 0353	238-5060 ext. 0329	238-5040 ext. 0272	238-5070 ext. 0229
	Fax (870)238-5053	Fax (870)238-5063	Fax (870)238-5043	Fax (870)238-5009

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Medication Administration Consent Form

Student Name_____DOB_____Grade_____HmRm_____

Name of Medication_____ Dosage_____

Time to be Taken_____ Ordering Physician_____

Reason for Medication_____

Other instructions_____ Epi Pen Expiration date: _____
IF APPLICABLE

Medication Procedures:

1. Only medications that are ordered and labeled to be taken with meals, at a specified time during school hours, **or 4 or more times** a day will be administered at school. Morning doses should be taken at home with a snack prior to coming to school.

2. Parent/guardian/designated adult must bring/sign in/count all medications, prescription and/or over-the-counter (OTC), to the nurse's office. Students are NOT permitted to have medication in their possession on the school bus or school campuses. **EXCEPTION: EMERGENCY** medications if consents/Doctor orders are on file in nurse's office; these must be renewed annually.

3. All medications must be in the original container with the student's prescription label in place. OTC medications should have the student's name written on it and have the manufacturer's dose and directions included.

I certify that at least one dose of this medication has previously been given (exception: emergency medication) with NO adverse reactions. Therefore, I give permission for the school to administer the above medication to my child according to the Board of Education procedure (see above). I will not hold the school staff responsible for any undesired reaction or effects which may occur from the medication. Only emergency medications will be sent on off-campus activities. I give permission for the school nurse to contact the prescribing doctor about medication(s) and to take a photograph of my child for identity purposes.

For an oral controlled substance, in the unavailability of a school nurse, ***the parent may delegate*** to the following designee: Dawn Hess (nurse's aide), _____, _____, to administer the medication at school or school event.

Signature of Parent/Guardian_____ Date_____

Contact Number_____

Allergy Action Plan

Student
Name_____DOB_____Grade_____HmRm_____

Weight_____ Asthmatic ___Yes ____NO

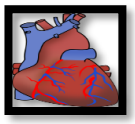
Allergy To: _____

Signs of an Allergic Reaction

Mouth and Throat
Itching and swelling of lips, mouth, tongue, or throat. Sense of tightness in mouth or throat hoarseness and hacking cough.

Skin
Hives, itchy rash, and/or swelling around the face or extremities.

Lungs
Shortness of breath, repetitive coughing, and/or wheezing.



Heart
Pale, blue, faint/weak pulse, dizzy, passes out.

Gut
Nausea, repetitive vomiting, severe diarrhea.

Other
Feeling something bad is going to happen, anxiety or confusion.

Actions for Minor reaction:
If symptoms are: _____,

Give_____, Route_____, Dose_____

Then call: 1st Name_____Number_____

2nd Name_____Number_____

Actions for Major Reaction:
If ingestion is suspected and/or symptoms are: _____

Give_____, Route_____, Dose_____

Call 911

Then call: 1st Name_____ Number_____

2nd Name_____ Number_____

Other Directions:

_____

_____CALL 911 IF NEEDED_____

Doctor Signature_____ Date_____

Parent Signature_____ Date_____

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Consent To Share Information

Student's Name_____

Student's Date of Birth_____

Student's School ID#_____

I authorize personnel of the Wynne School District and personnel with any relevant agency or provider to access and exchange information in my or my child's files that may be beneficial in providing any or all needed services. I understand that I am giving my permission to share confidential information in an effort to better serve the needs of my family.

_____

Print Name of Parent/Legal Guardian Date

_____

Signature of Parent/Legal Guardian Date

_____

Nurse Signature Date

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EPIPEN SELF-ADMINISTRATION CONSENT

Primary 238-5050, Intermediate 238-5060, Jr. High 238-5040, High School 238-5070

Student Name: _____ Birth date: _____ Grade: ____ HR: _____ School ID# _____

Parent/Guardian Name: _____ Physician Name: _____
(PRINT) (PRINT)

The following MUST BE PROVIDED to the school by the parent/guardian to the school before the student will be allowed to carry and use emergency medication while at school, at an on-site school-sponsored activity, or at an off-campus school-sponsored activity. This is only valid for this academic school year at Wynne Schools. A new plan and consent must be obtained each school year or any re-entry into the Wynne Schools:

PHYSICIAN -- As the prescribing physician, please verify the following for the above named student:

_____ Diagnosis(es): _____

_____ Name of medicine: EpiPen or EpiPenJunior or Other Rx: _____

_____ Student needs emergency medication while at school, including any school-sponsored activity, due to a medical condition.

_____ Student **CAN** demonstrate the skill level, understands the treatment plan, has the responsibility necessary to use and self-administer the prescribed medication

_____ **I DO NOT RECOMMEND THAT THIS STUDENT CARRY OR SELF-ADMINISTER THIS EMERGENCY MEDICATION.**

Physician signature: Phone numbers: Date:

PARENT -- As the parent/guardian of the above name student:

_____ I have discussed and agree with the treatment plan set up by the prescribing physician.

_____ I give permission for my child to carry and use emergency medicine while at school, at an on-site school-sponsored activity, or at an off-campus school-sponsored activity including any off-campus school activity.

_____ I agree and understand the school's student contract/agreement which my child has signed.

_____ I understand that I will supply my child's self-administered medicine, that it must have a current prescription label attached, be stored & transported in its original prescription-labeled container inside the student's backpack or purse. EXP DATE:_____

_____ I understand my child must not share, transfer, unpack, show to others, or in any way divert their emergency medicine to any other student or person or shall be subject to disciplinary measures according to the school board of education policies for drug abuse.

_____ I understand that if my child does not demonstrate reliable behavior while carrying his/her emergency medicine, he/she will lose this privilege and the medication will be kept in the school Health Office.

_____ I will notify the school nurse or principal of any changes in the student's condition, medication or dosage, or changes in emergency contact information.

No school employee, school agent, or school district shall be held liable for injury to a student caused by his/her use of self-administered medication.

Parent/Guardian signature: Phone numbers: Date:

STUDENT -- As the student, my responsibilities include:

_____ I understand the treatment plan documented by my prescribing physician.

_____ I can state the signs & symptoms of anaphylaxis/reaction and when I need to use my emergency medication as documented by my doctor

_____ I have demonstrated the skill necessary to use and self-administer my emergency medicine.

_____ I will immediately report to the school nurse (or designee) or principal – when I use my auto-injector so that emergency transportation to the nearest emergency facility can be called.

_____ I will carry my emergency medicine inside my backpack or purse in its original prescription-labeled container and will only take it out to self-administer the medicine for a medical emergency.

_____ I will not share, transfer, unpack, show to others, or in any way divert my emergency medicine to any other student or person, I shall be subject to disciplinary measures according to the school board of education policies for drug abuse.

_____ I understand that if I do not demonstrate reliable behavior while carrying my emergency medicine, I will lose this privilege and the medication will be kept in the school Health Office.

Student signature: Phone number Date

NURSE --

_____ Received Allergy Action Plan from student's physician with MD signature.

_____ Physician signed MD section of this form.

_____ Student **can** demonstrate the skill level and verbalizes understanding of the treatment plan and correct administering procedure.

_____ Student **cannot** demonstrate the skill level and verbalizes understanding of the treatment plan and correct administering procedure (explain below).

_____ Student signed above contract and verbalizes understanding.

_____ Signature completed in Parent section of this form and verbalizes understanding.

_____ Parent completed and signed authorization to release information form.

_____ Parent signed Medication Administration Consent form.

Additional Comments:

_____

_____

_____

_____

Nurse Signature: Date: