Office of the CCSD School Nurse

Dear Parent /guardian,

You have indicated that your child: ____
has **ASTHMA, ALERGIES OR A SEIZURE DISORDER. Mississippi State law requires that we have:**

- **ACTION PLAN SIGNED BY YOU AND CHILD'S DOCTOR (whether the child is on medication or not)**
- **CCSD MEDICATION AUTHORIZATION FORM AND PROCEDURE FORM SIGNED BY YOU AND CHILD'S DOCTOR**
- **PERMISSION TO SELF ADMINISTER CHECKED ON PLAN(S) THAT IS SIGNED BY DOCTOR (IF YOUR CHILD IS TO CARRY INHALER OR EPI- PEN)**

IF YOUR CHILD IS NOT CURRENTLY UNDER A DOCTOR'S CARE IN ANY WAY OR RECIEVING ANY TREATMENT OR MEDICINE PLEASE CHECK THE BOX BELOW WHERE INDICATED AND SIGN AND DATE THE FORM AS INDICATED.

_________ My child is not currently under the care of a physician for asthma and is currently not taking any medication for asthma. I acknowledge being informed of the new asthma law. If my child's health status changes and a diagnosis of ASTHMA,ALLERGIES OR SEIZURES is given or medication is started, I understand that I am to provide the school with the above information.

Date: ____

Parent /Guardian ________________________________

Thank you again -

CCSD School Nurse

Please fax back to your child's school

AES- (662) 285-4099 **CCHS- (662) 285-4149**
WES- (662) 547-7074 **FCE- (662) 547-7119**

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________________ D.O.B.: ____________

Allergy to: ______________________________

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

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________________

THEREFORE:

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

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________________

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if wheezing): ______________________

____

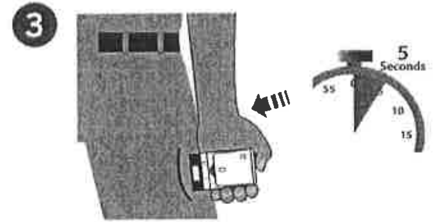
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FARE
Food Allergy Research & Education

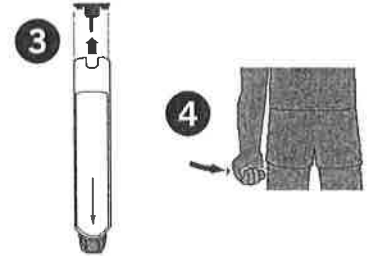
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



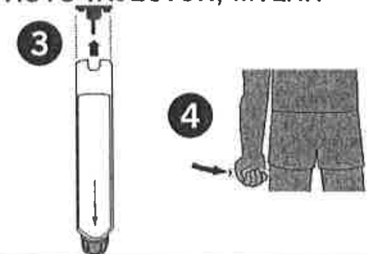
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN



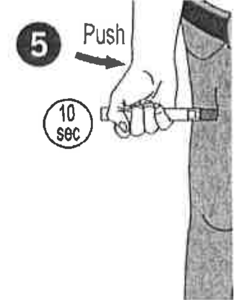
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN



1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________________

DOCTOR: ______________________ PHONE: ______________

PARENT/GUARDIAN: ______________________ PHONE: ______________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________________

PHONE: ______________________________

NAME/RELATIONSHIP: ______________________________

PHONE: ______________________________

Self-Administer Medication Permission Form

(Auto-injectable epinephrine and/or rapid-acting bronchial inhalers ONLY)

Student: ____ Date: _______________

This letter confirms that the above-named student is a current patient and is being treated for (i.e., health condition): ___________________________________

____

I agree that the student is responsible and capable of self-administration of the following medications at school (please check those that apply):

_____ **Rapid-acting bronchial inhaler (please include name, dose, and frequency of the medication:** ____

_____ **Auto-injectable epinephrine (please include name, dose, and frequency of the medication:** ____

***The medications must remain in their original container(s) with the prescribing information intact.*

Healthcare Provider Signature: ____

I, the parent/guardian of ____________________________ agree that my child is responsible and capable of self-administration of the above medication(s). I accept full responsibility and liability for my child carrying and self-administering this medication(s).

Parent/Guardian Signature: _____________________________ Date: ___________

I, ______________________ (student) agree that I am being given permission by my healthcare provider, my parent(s)/guardian, and my school to carry and take my own above-named medication(s) as needed. I will keep the permitted medication in my book bag/locker. I will not share with or give my medication to anyone. I will not take my medication for any reason except as prescribed. I understand that my parent(s) and I accept full responsibility for my carrying and taking my own medication as prescribed above. I understand that I will lose the privilege of carrying the medication if I misuse it or do not adhere to the above rules.

Student Signature: _____________________________________ Date: __________

School Nurse Signature: _________________________________Date: __________

This form must be renewed each school year.

CCSD OFFICE OF THE SCHOOL NURSE

Procedures for Administering Medications to Students

The first dose of any newly prescribed medication should be given at home. **Medications that are to be given only one time a day or medications that can be given before or after school should be given at home.** In the absent of the school nurse, a designated school personnel is authorized to give prescribed medication. **Since parents are primarily responsible for administering medication to their child, we encourage you to come to school to administer needed medication to your child.** However, Choctaw County School District does recognize there are circumstances when it is necessary to administer medication to a student during school hours. This may enable the student to attend school, improve or maintain their health status and/or improve their potential to learn. For the safety of our students, the following procedures will be followed:

1. If your child has to take medicine at school, **the school must receive a Choctaw County School District Medication Permission Form signed by the parent AND the child's health care provider**, stating the name of the medication, dosage, route, and the time the medication is to be given at school. Permission Forms are required for both prescription and over the counter medication.

2. A new medication permission form must be completed each school year and for each medication and whenever there is a change in the student's authorized healthcare provider, or a change in the medication dosage, method by which the medication is required to be taken, or date or time the medication is to be taken.

3. **DO NOT SEND MEDICATION TO SCHOOL WITH STUDENTS**. All prescribed medication is to be brought to school by the parent or guardian in a container **labeled by the pharmacist**. The information on the container must match the information on the medication permission form. Any change in the prescription requires a new permission form. Pick up all discontinued, outdated or unused medicine before the end of the school year. Medications not picked up will be discarded in an appropriate legal manner.

4. Students with emergency medications, such as inhalers, insulin, or epi-pens, may carry and self-administer these medications only if the healthcare provider and parent sign the permission form and it is on file at school. Parents of these students are advised to contact the school nurse.

5. It is the parent's responsibility to ensure that their child has needed emergency medications on field trips and school sponsored events. If your child requires medication on a field trip, we encourage the parent to accompany the child. If this is not possible, the medication will be administered under the supervision of your child's teacher.

I understand and agree to the above procedures regarding medication administration.

____

Parent Signature **Date**

____

Student's Name **Teacher's Name**

Please fax back to your child's school

AES- (662) 285-4099 **CCHS- (662) 285-4149**

WES- (662) 547-7074 **FCE- (662) 547-7119**

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR

SCHOOL MEDICATION PERMISSION FORM

This form **must be completed fully by parent and physician** in order for schools to administer prescribed medication. **A NEW Medication Permission form must be completed** each school year for **EACH** medication and whenever there is a change in the student's physician, or a change in the medication dosage, method by which the medication is required to be taken, or date(s) or time(s) the medication is required to be taken.

TO BE COMPLETED BY PHYSICIAN

Student's Name: ______________________________ **Allergies**__________

Diagnosis: ____

Medication Name: ____________________________________

Route: __________ **Dosage:** ________________ **Time** ______________

Side Effects: _______________________________________

Is it necessary for this medication to be administered at school: YES______**NO**________**?**

Other medication student is taking______________________________

______________________________ ____________________

****** Physician Signature****** **Date**

PARENTS' AUTHORIZATION

I give permission for the school nurse or delegate to administer the above prescribed medication to my child. I give my consent for the Choctaw County School District to contact my child's physician regarding administration and effectiveness of prescribed medication. I agree to release the Starkville School District and its employees who are acting within the scope of their duties from any liability or compensation in any and all claims arising from the administration of medication at school to my child. I understand that I may refuse consent for this permission at any time by notifying the school nurse or principal in writing. I also understand that the nurse may reject requests for administration of medication. I understand and agree to the following responsibilities regarding medication administration:

1. The first dose of any newly prescribed medication should be given at home.

3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school and pick up any outdated or unused medication.
5. DO NOT SEND MEDICATION TO SCHOOL WITH THE STUDENT *EMERGENCY MEDICATIONS ARE ALLOWED AFTER MEETING REQUIREMENTS

______________________________ ____________________

Signature parent/legal guardian **Date**

Please fax back to your child's school

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WES- (662) 547-7074 **FCE- (662) 547-7119**

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR

MEDICAL RECORDS RELEASE

CHOCTAW COUNTY SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE

I__________________________________ as legal representative of

PARENT/GAURDIAN

__________________________________ do hereby give consent for the release

STUDENT

of the following medical information to Choctaw County School District to the care of the school nurse:

____

The school district shall keep this information confidential and shall not re-release the information without the written signed consent of the above named parent/guardian.

____________ ____________________________________

Date **Signature of Parent/Guardian**

Please fax back to your child's school

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WES- (662) 547-7074 **FCE- (662) 547-7119**