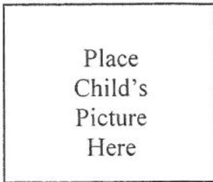
Allergies

ACCEPTING MEDICATION FROM PARENTS – FAQ's

- Prescribed medications required to be given during school hours will be accepted.
- Over-the-Counter (OTC) medications will be accepted and administered for temporary medical conditions for a period no longer than 5 calendar days, and cannot be renewed beyond 5 days without a healthcare provider's written authorization.
- All medications must be transported to and from school by a parent, legal guardian, or designated adult.
- Before assisting any student with medication, a Medication Permission Form must be completed and signed by a parent or legal guardian.
- A separate Medication Permission Form must be completed for each medication, and is valid for the current school year in which it is completed (prescription medications only).
- All medications must be in the original container or packaging, and must contain labeled dosing instructions.
- Medication and doses of medication must be age-appropriate. Some non-prescription medications are not recommended for children. Check the box/bottle for this information.
- Before leaving medications at school, all medications must be counted, verified and documented by the parent / guardian and staff member on the Medication Log.
- Medications containing aspirin (Excedrin, Goody Powder, etc.) will not be accepted without a physician's written order, due to the association with Reye Syndrome.
- Only FDA-approved medications will be accepted. No vitamins, nutritional supplements, etc.
- Parents / Guardians may not change the dose or time of administration of any prescription medication. A physician's written order or new prescription bottle reflecting the change is required.
- Completed Medication Permission Forms must match the prescription or OTC dosing instructions.
- Students who carry medications allowed by Florida Statutes must have a completed Medication Permission Form and a written order from the physician to carry the medication on file in the school clinic.



LEON COUNTY SCHOOLS
Individualized Student Allergy Action Plan for 20____-20____ School Year

Student Name: ______________________________ DOB: ______________

School: ____________________ Grade: _____ Teacher/Homeroom: ____________________

ALLERGY TO: ____

Asthma Diagnosis? ☐ Yes* ☐ No *Higher risk for severe reaction

STEP 1: TREATMENT – This section to be completed by PHYSICIAN authorizing treatment

Symptoms:		Give Checked Medication:	
▪ If exposed to allergen, but ***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

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

MEDICATION AND DOSAGE:

Epinephrine: Inject intramuscularly (circle one or list) EpiPen EpiPen Jr. Other: ______________

Antihistamine: Give by mouth ____
medication/dose

Other: Give ____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. **Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed. EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911!**
2. Dr. ______________________ at ______________________
3. Emergency contacts: Name/Relationship Phone Numbers

1. ______________________ h __________ w __________ c __________

2. ______________________ h __________ w __________ c __________

3. ______________________ h __________ w __________ c __________

Parent/Guardian Signature ______________________________ **Date** __________

Doctor's Signature ______________________________ **Date** __________
(Required)

LOCATION OF INJECTABLE EPINEPHRINE: ______________________________

Reviewed By LCHD School RN Signature: ______________________ Date: __________
IHP ☐

AUTHORIZATION FOR MEDICATION OR TREATMENT

(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, ______________________________(first/last name)/_______________ (date of birth), to be given the medication or treatment listed below during the school day, including when s/he is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: ____

Reason for medication (diagnosis): ____

Dosage to be given: ______________________________ Route (mouth, injection, etc.): ______________

Time(s) of administration: ______________________________ Allergies: ______________________

Beginning date:______________ Ending Date: ______________ Amount of liquid or count of pills: ______________

Emergency telephone numbers:

Parent/Guardian:______________________________H: ______________________C: ______________

Parent/Guardian:______________________________H:______________________C: ______________

Doctor's Name:______________________________Doctor's Phone Number:______________________

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered up to **five calendar days** without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy **(see back of form).**

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Date______________________ Parent/Guardian Signature______________________________

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Time(s) of administration: __________________________ Allergies: ______________________

Beginning date:_______________ Ending Date: ___________ Amount of liquid or count of pills: ___________

Emergency telephone numbers:

Parent/Guardian:______________________________H: ____________________C: ________________

Parent/Guardian:______________________________H:____________________C: ________________

Doctor's Name:__________________________Doctor's Phone Number:_________________________

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Date______________________ Parent/Guardian Signature______________________________

Specialized Health Care Procedure:

Administering Emergency Injectable Medication (EpiPen)

Purpose: Anaphylaxis is an allergic reaction of the body to a foreign protein or drug. Sudden and severe reactions in the body affect the heart and respiratory systems. School personnel need to know which students have been prescribed an EpiPen for allergic reactions and to be aware of where these students are during the school day to react calmly but swiftly in an allergic reaction situation.

Requirements: Parents/guardians are required to complete and sign a medication permission form at the student's school. An Allergy Action Plan, completed by the prescribing physician, must be signed by the physician and the parent. Parents/guardians are required to supply all medication and equipment needed to administer the medication.

Personnel authorized to perform procedure: Can be performed by an RN or LPN, or by any designated staff member trained by the nurse. Training will be reviewed on a yearly basis.

Equipment required: EpiPen syringe with prescription information printed on the box.

Special Considerations: Administration of an emergency injectable (EpiPen) is done to relieve a life-threatening situation. It is important that the rescue squad ("911") be called to assess the student's reponse to the medication or to determine further needs. The student should never be left alone during this situation.

Procedure:

1. Depending on the status of the student, either have him/her brought to the clinic/office foe care, or have the trained person with the EpiPen go to the student's location.
2. Identify the need for administration of the EpiPen according to the student's individual Allergy Action Plan. Symptoms may include any of the following: shortness of breath, hives, itching, redness of the skin, sneezing, coughing, wheezing, constriction in chest or throat, difficulty swallowing, confusion, and a feeling of impending disaster.
3. Have someone call 911 and tell them that a student is having a severe allergic reaction and you are about to administer an EpiPen.
4. Verify that the name on the prescription box is the same as that of the student to receive the injectable.
5. Administer the EpiPen with the student lying down:
   - Pull off the blue safety cap.
   - Hold the orange tip near the skin on the upper outer thigh.
   - Swing and jab firmly into outer thigh until auto-injector mechanism functions
   - and hold in place for 10 seconds. (Can go through clothing.)
   - Massage injection area for 10 seconds..
   - Place used EpiPen in storage container and give to EMS.
6. Notify parents/guardians and prepare for the arrival of paramedics. Be prepared to perform CPR if needed.
7. Follow up later in the day with the parents/guardians to check on the condition of the student, and to be sure they bring another EpiPen to school before the student returns.

Parent Authorization for Specialized Health Care Procedure

I, the undersigned, who is the parent/guardian of

____

request that the following health care service:

Administering Emergency Injectable Medication (EpiPen)

be administered to my child. I understand that a trained designated staff member will be performing this procedure. It is my understanding that in performing this procedure, the designated person(s) will be using a standardized procedure which has been approved by our physician. I will notify the school immediately if the health status of our child changes, I change physicians, or there is a change or cancellation of the procedure.

Signature of parent/guardian ____________________

Date ____________________

Physician's Order for Specialized Health Care Procedure

Student's Name ____________________________ DOB ____________

Procedure: **Administering Emergency Injectable Medication**

Check one:

_____ I have reviewed the Health Care Procedure and approve of it as written.

_____ I have reviewed the Health Care Procedure and approve of it with the attached amendments.

_____ I do not approve of the Health Care Procedure. A substitute procedure is attached.

Duration of the procedure (not to exceed current school year): __________

Physician's Signature: ________________________ **Date:** _________

Florida Department of Health in Leon County

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year___________

Student's Name: ________________________________
DOB: ________________________________
School: ________________________________

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health inLeon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial <u>all</u> that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: ________________________________)
___ [X] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician________________________________
(Please fill in Physician name)
___ [ ] Specialist Physician________________________________
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

________________________________ ____________________

Signature Date

Florida Department of Health
In LEON COUNTY- School Health
2965 Municipal Way • Tallahassee, FL 32304
PHONE: 850/606-8183• FAX: 850/487-7954

Leon County Schools

AUTHORIZATION TO CARRY MEDICATION(S) PERMITTED BY FLORIDA STATUTE 1002.20:
ASTHMA INHALERS, EPINEPHRINE AUTO-INJECTORS, DIABETES SUPPLIES OR PANCREATIC ENZYMES

Date: ____________________

Student Name: ____________________________________ DOB: __________________

School: ____________________________________ Grade: __________________

It is medically necessary for this student to carry his/her medication and/or supplies while in school as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

This authorization is valid for the current school year only (if for specific dates, please specify).

Medication and/or Supplies: ____

____

Dosage/Instructions: ____

____

Diagnosis: ____

Physician Signature	**Physician Name**	**Phone Number**	**Date**

I have read and understand the waiver of liability statements on the Authorization for Medication (Page 1) and feel that my child is capable of self-management and administration of the above medication/supplies.

Parent Signature	**Parent Name**	**Phone Number**	**Date**

*****For staff use only*****

The student has demonstrated that he/she is responsible in the use and storage of the above medication.

FDOH RN Signature	**FDOH RN Name**	**Phone Number**	**Date**