ARCHDIOCESE of MILWAUKEE

Form
5141.5 (a)

PARENT(S)/GUARDIAN MEDICATION AUTHORIZATION FORM
NONPRESCRIPTION MEDICATION

STUDENT'S NAME:	DOB:
SCHOOL:	GRADE:
DIAGNOSIS:	

As the parent and guardian of the above mentioned student, I give the school permission to administer the following medication(s) to my child for the diagnosis/reason listed above:

MEDICATION NAME	DOSAGE: (MG, CC, ML, ETC)	ROUTE: (HOW IT IS TO BE GIVEN)	FREQUENCY: (HOW OFTEN)	START DATE	STOP DATE	SIDE EFFECTS
1.						
2.						
3.						
4.						

As the parent or guardian of the above mentioned student, I will keep the school aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, schools are required to have permission from a parent/guardian to administer nonprescription medications at school. As part of this authorization form, school employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

All medications must be in the original container listing the recommended therapeutic dosage. Administration of a dosage other than the recommended therapeutic dose may be given only if the written request to do so is also accompanied by the written approval of the child's medical provider.

PARENT(S) GUARDIAN SIGNATURE:	DATE:

Form
5141.5(b)

MEDICAL PROVIDER AUTHORIZATION FORM
PRESCRIPTION MEDICATION

Student's Name:	DOB:
School:	Grade:
Diagnosis:	

DAILY MEDICATION

Medication:	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
1.						
2.						

AS NEEDED OR PRN MEDICATION

Medication:	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
1.						
2.						

MEDICAL PROVIDER CONSENT

I authorize the school to the give the above medication(s) to this student.

Asthma Inhalers and Epi-Pens Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self administer at school. Yes ☐ No ☐

Print Medical Provider Name:	Date:
Medical Provider Signature:	

PARENT CONSENT

I give the school permission to administer the above medications as directed by the medical provider.
Inhaler/Epi-Pen Only: My child may ☐ or may not ☐ carry and self-administer.

Parent/Guardian Signature:	Date:

As part of the authorization form, school personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

Form
5141.5 (c)

Allergy Action Plan

Student Name: _____ Birth Date: _____
School: _____ Grade: _____ Teacher: _____

Place Student Photo Here

ALLERGIC TO THESE ALLERGENS: _____

☐ **Has Asthma** (increases risk for severe reaction)

☐ **Severe Allergy previously/suspected—Immediately give epinephrine & call 911– Start with Steps 2 & 3**

☐ **Mild Allergy –** Itching, rash, hives – **Give antihistamine, call school nurse and parent. Start with Step 1**

► STEP 1: IDENTIFICATION OF SYMPTOMS* ◄

*** Send for immediate adult assistance**

Symptoms:		**Type of Medication to Give:** (Determined by physician authorizing treatment)
➢	If exposed to allergen, or allergen ingested, 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: Call 911**
➢ **Heart** –**	Faint, pale, blueness around mouth or nail beds, weak pulse, low B/P. .	☐ **Epinephrine: Call 911**
➢ **Other** –**	_____	☐ **Epinephrine: Call 911**
➢	If reaction is progressing (several of the above areas affected) give	☐ **Epinephrine: Call 911**

**** Potentially life-threatening.** – Note: The severity of symptoms can quickly change.

► STEP 2: GIVE MEDICATIONS ◄

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® ☐ EpiPen Jr®

- **If Epinephrine is given, paramedics must be called! PROCEED TO STEP 3 BELOW.**

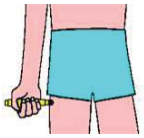
Antihistamine/other: give _____ *(Medication name & amount)* **by** _____ *(route/method)*

- **Notify** parents and school nurse • **Observe** for increasing severity of symptoms • **Call 911** as needed

IMPORTANT: Do NOT depend on asthma inhalers and/or antihistamines to replace epinephrine in a severe reaction.

EpiPen Directions:

a. Pull off the GRAY Safety Cap
b. Place BLACK TIP near OUTER-UPPER THIGH
c. Swing and jab firmly until hearing or feeling a click
d. Hold EpiPen in place **10 SECONDS**, remove, massage area
e. Dispose of in red sharps container or give to paramedics



- The EpiPen can be injected through clothing.
- The individual may feel his/her heart pounding.
  - This is a normal reaction to the medication.

► STEP 3: EMERGENCY CALLS ◄

1. **CALL 911** – *Seek emergency care*. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Parents or Emergency Contacts

Parent completes Parent and Emergency Contact Names and Information below:

Parents/Emergency Contact *Names*:	*Relationship:*	*Phone Number(s):*
a. _____	1.) _____	2.) ( ) _____ ( ) _____
b. _____	1.) _____	2.) ( ) _____ ( ) _____

Parent/Guardian Signature _____ Date _____
(Required)

Physician completes form through Step 2

Physician Name (Printed) _____ Phone Number: ( ) _____

Physician Signature _____ Date: _____
(Required)

This form must be renewed annually or with any change in medication.
The *Prescription Medication Authorization Form* must be completed in addition to this *Allergy Action Plan*

Form
5141.5 (d)

HEALTH CARE ACCOMMODATIONS PLAN

LIFE THREATENING FOOD ALLERGY
(SAMPLE)

STUDENT:	SCHOOL:	GRADE:
ADDRESS:	CITY:	DOB:
PARENT/GUARDIAN:	PHONE:	

I. MEDICAL CONDITION

Student has a life threatening food allergy and is subject to possible severe allergic reactions including anaphylaxis.

II. CLASSROOM/SCHOOL ACCOMMODATIONS (Modify as needed.)

School does not guarantee elimination of any and all food products that may cause the student to have an allergic reaction. The school will hold in the best interest of the child and make any reasonable accommodations to assist with the allergies. The school will in good faith follow the accommodations listed as follows:

School:
- Parents will provide EpiPen for the classroom/ office/cafeteria.
- Food Allergy Action Plan will be posted in agreed upon locations.
- Student must be accompanied to health room/office if suspected of having an allergic reaction.

Classroom:
- The student is allowed to eat only those foods approved and/or provided by the parent.
- The school will send a safe snack letter of notification to parents of all classmates of the student.
- Parent should be advised of any planned parties and/or projects involving food as early as possible.
- An informational sheet/packet will be prepared for substitute teacher.

Cafeteria:
- The student will be allowed, as a request by his parents, to sit at any cafeteria table. This table will receive an extra cleaning daily to prevent cross allergen contamination.
- The student will sit at a designated allergen-aware lunchroom table.
- The lunchroom/playground supervisors should be alerted to the student's allergy.
- Parents will be given a lunchroom menu monthly for their review of food items being served.

Field Trips:
- Parent will be advised of any planned field trips and allowed to accompany if possible.
- Parents will accompany their child on field trips.
- Trained staff person will review health care plan and use of emergency medication prior to trip.
- EpiPen must accompany student during any school related off campus activities.

Bus:
- The student requires preferential seating on the bus.
- Driver has been alerted to student's allergy.

Student Considerations:

- Student is able to recognize signs and symptoms of exposure to allergen. Yes ☐ No ☐
- Student knows how to access emergency help in the school setting. Yes ☐ No ☐
- This student is authorized to self-carry/self-administer an EpiPen. Yes ☐ No ☐
- This student needs assistance in administering an EpiPen by trained personnel. Yes ☐ No ☐

Parent Authorization:

- I give the health care provider permission to release pertinent medical information to the school regarding the administration of medication to my child.
- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use.
- I agree to supply an Allergy Action Plan to the school for my child.
- In the event of an emergency, I give my permission for transport and treatment at the nearest medical facility.
- I agree to hold the school and its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of emergency medication at school.

PARENT SIGNATURE:	DATE:
PRINCIPAL SIGNATURE:	DATE:
HOMEROOM TEACHER SIGNATURE:	DATE:

By entering my full name, I attest that this constitutes my legal electronic signature on this form.
Revised: 6/14/2012