EASTERN SCHOOL DISTRICT
FORM A - PARENT/GUARDIAN MEDICATION CONSENT AND RELEASE FORM

(To be completed by Parent/Guardian)

Student Name: _____D.O.B: _____
Address:_____
Emergency Contact(s): _____ Tel #: _____
School: _____ School Year: _____
Grade/Level: _____ Room/Class: _____ Teacher: _____

Prescribed Medication:

I hereby request, authorize and empower the Eastern School District to administer medication as described herein or treatment as described in Form B (see attached) to the student named above. I release the Eastern School District and any staff member of the student's school from any legal liability that may result from the administration of such medication or the giving of such treatment. I also agree to indemnify the Eastern School District against claims at any time made by the student named or by any other party arising
out of the administration of medication or treatment described herein to my child.
I further acknowledge awareness that school staff members are not medically trained personnel and that my expectations of school personnel in the knowledge and administration
of medication to my child or any other child shall be no greater than that of their professional field.

PARENT/GUARDIAN PERMISSION:

I request and give consent to allow a staff member to administer this prescribed medication
at school with the in full realization that that person is not a medically trained person.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Signature of Witness

EASTERN SCHOOL DISTRICT
FORM B - PHYSICIAN'S REPORT

Student Name: _____ D.O.B:._____
Address :_____ MCP#:
_____
Parent/Guardian(s): _____
Medical condition requiring treatment during school hours: _____
_____

TYPE OF IN-SCHOOL INTERVENTION NECESSARY;

1. Medication(s):

Medication Prescribed
Dose
Frequency
Required Time of Administration
Method of Administration
Purpose of Medication

2. Other (be specific):

_____
_____

3. **CONSIDERATIONS**

a. Possible side effects of medication(s)/treatment and remedial action for side effects

_____
_____

EASTERN SCHOOL DISTRICT
FORM B - PHYSICIAN'S REPORT
(CONTINUED)

b. Type of storage and safe keeping required for medication _____
_____
_____

c. Will it be detrimental to the student's health if a single dose/treatment is omitted?
Yes ____ No ____

d. Please check the appropriate box to complete this statement:
Persons administering the medication/treatment as described above
____ **do need** to have had medical training or certification by the Community Health Nursing Division
____ **do not need** to have had medical training or certification by Community Health Nursing Division

3. The student named above must have this medication/procedure administered/performed during school hours in order to be able to attend school
Yes ____ No ____

4. Is this student able to administer his/her own medication? Yes ____No ____
If yes, give details:
_____
_____

_____
Signature of attending physician

_____
Name of attending physician and telephone numbers

EASTERN SCHOOL DISTRICT
FORM F - SELF-ADMINISTRATION OF MEDICATION BY STUDENT

A. TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ Address: _____
Parent/Guardian name(s): _____ Tel.#'s: _____
Emergency Contacts: _____ Tel.#' 's: _____
School: _____ Grade/Level:
_____

I hereby consent to my child administering his/her own medication as described herein. I release the Eastern School District and any employee from any legal liability with respect to my child's administration of his/her medication. I also agree to indemnify the Eastern School District against any claims made by the student or by any party arising out of my child's self administration of medication or treatment described herein.

I have discussed the importance of the responsible security and handling of this medication with my child.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness-Principal/Vice Principal Date

Please Note: This will need to be witnessed by an employee of the Eastern School District.

EASTERN SCHOOL DISTRICT
FORM F - SELF-ADMINISTRATION OF MEDICATION BY STUDENT (CONTINUED)

B. TO BE COMPLETED BY PHYSICIAN

Medical condition requiring treatment _____
_____
_

Prescribed Medication, Dosage and Daily Schedule of Administration:
_____
_
_____
_
_____
__

The student named above is capable of administering his/her own medication without any supervision from any employee of the Eastern School District staff and is capable of keeping his/her own medication in his/her possession for this purpose.

_____ _____
Signature of Attending Physician Telephone Number(s)

C. FOR OFFICE USE ONLY

Date Submitted to Office: _____ Principal's Signature: _____
Teacher(s) Notified: ____ No ____Yes Date

EASTERN SCHOOL DISTRICT
CONSENT FORM FOR STUDENTS WITH LIFE-THREATENING FOOD ALLERGIES

_____(student's name) has been identified as having a serious allergy and the
school would like to take the following precautionary measures:
1. Post an Anaphylaxis Alert form complete with a photograph of your child, a description of the allergy,
and an action plan in key locations in the school.
2. Provide all staff (including substitute teachers) with information concerning your child's allergy as
described in the Anaphylaxis Alert form.
3. Identify students who have anaphylactic allergies to parent volunteers.

To assist the school in carrying out these precautionary measures, the school requests the following:

1. An Anaphylaxis Alert form with an individualized action plan, signed by a physician.
2. One up-to-date photograph of your child that can be photocopied clearly for use on the forms.
3. All medications listed on the action plan, including two auto-injectors (EpiPens®), labeled with
the student's name and the expiry date of the medication.

IMPORTANT: If the parents provide the school with only one EpiPen®, it will be kept in a secure, accessible area as designated by the school administration.

Please sign below to indicate your consent to the above measures and return the form to the Principal.
Please contact the school if you have any concerns.
I, _____, parent/guardian of _____(student) attending _____ school, hereby consent to the school taking the precautionary
measures listed in items one to three above, and further agree to provide the school with the items referred to
in items numbered four to six above.

_____ _____
(date) (signature of parent/guardian)

_____

EASTERN SCHOOL DISTRICT
ADMINISTRATION of EMERGENCY MEDICATION

Student's Name _____Homeroom/Teacher_____
Student Address_____
Name of School _____ Name of Principal _____
Location of Emergency Medication _____
The above named student has a medical condition known as _____
that may require treatment with **emergency medication(s)** during school hours.

Emergency Medication Information

Name/type of medication: _____
Dosage/amount to be given: _____
Method of administration: _____
Frequency/times to be administered: _____
Duration: _____
Type of storage required for Medication: _____
Anticipated reaction to medication (symptoms, side effects, etc.): _____
_____

Request

We are writing to request that the principal or designate administer the medication known
as _____ to _____
(Name of Medication) (Name of Student)
in the event that he/she experiences _____
(Name of Medical Condition)

_____ _____
Physician's Signature / Date Parent (Guardian) Signature / Date

OPTIONAL:

The student named above may keep his/her medication in his/her possession. I have discussed the importance of the responsible security and handling of this medication with my child. In an Emergency, the student may administer his/her

Interim Policy
July 2005

ANAPHYLAXIS ALERT
Life Threatening Allergies

Student_____ Grade/Teacher_____

LIFE THREATENING ALLERGIES TO:

_____

Exposure to minute amounts of this allergen can be dangerous to the child. At all times this child must AVOID:

_____

A CHILD WITH A LIFE THREATENING ALLERGY MUST ALWAYS HAVE ADRENALINE (EPIPEN/ Ana-Kit)

Eating Rules/Activity Rules:

_____

Photo of Child

Contacts

Parent / Guardian:

Tel:

Parent / Guardian

Tel:

Hospital:

Tel:

POSSIBLE SYMPTOMS OF ANAPHYLAXIS: (Check symptoms commonly experienced by the child, but all symptoms are possible)

___Tingling in mouth	___Feeling of fear / anxiety	___Hives / Itching	___Wheezing
___Swelling-eyes, lips, face, tongue	___Tightness in throat / chest	___Flushed face / body	___Dizziness /unsteadiness
___Vomiting / stomach upset	___Coughing / Choking	___Difficulty breathing/ swallowing	___Loss of consciousness
			___Other

ACTION PLAN:

1. Use ADRENALINE immediately at first sign of symptoms. (Give into outer thigh and hold in place for 10 seconds)
   ADRENALINE is located_____
2. Have child spit out food and rinse mouth. Wash contact area.
3. Give additional medication, if any:_____
4. Transport child immediately to medical facility by ___ car or ___ ambulance(tell dispatcher child is having an anaphylactic reaction)
5. Have someone telephone the medical facility to inform them of the incoming child.
6. Administer additional ADRENALINE during transport every 15-20 minutes , if available, if breathing difficulties are present.
7. Suggest the child be monitored in medical facility for at least 8 hours, even if symptoms subside. Symptoms may reoccur.

Date:_____ Physicians Signature:_____

AIRHEADS/ALLERGIES, Parent Support Group, Lung Association, March 1999

ASTHMA INFORMATION

Asthma Triggers:

_____

_____

_____

Symptons of Asthma Episode:

_____

_____

_____

_____

_____

Medication Provided for Asthma Relief (Where is medication located?):

_____

_____

_____

_____

_____

Instructions for Asthma Episode:

_____

_____

_____

_____

_____

_____

_____

ANAPHYLAXIS ALERT FORM

EASTERN SCHOOL DISTRICT
ANAPHYLAXIS ALERT FORM FOR BUS DRIVERS

In the event of an Anaphylactic Reaction the bus driver must:

- Bring the bus to a complete stop in a safe area;
- Advise all passengers to remain seated;
- Ask for assistance in removing the allergic food from the bus;
- Administer the auto-injector (EpiPen®) - if authorized and trained;
- Follow the Emergency Response Procedures, which includes contacting emergency officials for assistance.

Student Information:

Student's Name:_____
School: _____
Grade: _____
Address:_____
Phone Number: _____
Bus Route/Name: _____

Photo

Emergency Contacts:

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____
Family Doctor: _____ Phone Number: _____

Medical Information:

Anaphylactic To:

_____

Carries EpiPen

EASTERN SCHOOL DISTRICT
SPECIAL FIELD TRIP CONSENT FORM

Conditions of Field Trip:

- The school is aware that your child has a life-threatening allergy.
- The teacher in charge of the field trip has received an in-service on Anaphylaxis and the administration of
emergency medication (EpiPen®).
- This teacher is responsible for bringing the emergency medication(s) on the field trip for primary/elementary students and for ensuring that junior/senior high students carry it.

Name of teacher in-charge of the field trip:_____
The student will be traveling by (please check ( ) the appropriate boxes):
Bus Foot Other:_____
In the event of an Anaphylactic emergency, the teacher in-charge of the field trip will:

- administer the EpiPen®
- call local emergency officials (911 if applicable)
- ensure the student is transported to the nearest medical facility via ambulance
- contact the parents

_____

Statement of Permission:

I have read the above conditions of the field trip and **give** permission for
_____ (student's name) to attend the field trip to
_____ with _____(school's name)
on
_____ (date).
I will accompany my child on the field trip (please check ( ): Yes No
Further Comments: _____
_____

Statement of Refusal:

I **do not** give permission for _____ (student's name) to attend the field trip to