Teacher :_____Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

Hope Charter School or Legacy High School

My permission is hereby granted to _____
School

To assist_____ DOB ____/____/_____
Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask you pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS**. Notes from home will not be accepted as authorization for dispensing medication.

_____ _____/_____/_____
Signature of parent/guardian Date

( )_____ ( )_____ ( )_____
Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.

08/01/11

Authorization for Self-Carry/Administration of Metered Dose Inhalers During and After School Activities

Hope Charter School or Legacy High School

FS 409.9071 Section 232.47 states that an asthmatic student may be able to carry a metered dose inhaler on their person while in school when they have written approval from the parent/guardian and physician. The principal shall be provided with a copy of the parent/physician's approval.

Student: _____ DOB: _____ Grade: _____

School: _____

Medication: _____ Dose: _____ Time: _____

Method of Administration: Metered Dose Inhaler Spacer: (Y/N) _____

Diagnosis: _____

Possible Side Effects/Precautions/Recommended Interventions: _____

_____

Duration (dates) of Administration: From: _____ To: _____ (Limit: One year).

I request that my child be allowed to carry/self-administer his/her medication and be responsible for its proper storage and use. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

_____ _____ _____

Parent/Guardian Date Daytime phone number

I have demonstrated the correct use/administration of this medication and agree to terms of this contract. I will keep medication in agreed location, will not share medication with others, and will come to the Clinic/Health Room if my symptoms continue or worsen after using medication:

Symptoms: _____

_____ _____

Student Date

I authorize this student to carry/self-administer the above medication. He/she has been trained to recognize signs and symptoms of asthma/breathing difficulties and how to correctly use the inhaler by me and/or my office staff.

_____ _____

Physician's Name/Stamp Phone number

_____ _____

Physician's Signature Date

☐ Extra inhaler in Health Room ☐ Original in Clinic/Health Room ☐ Copy to Student

Rev.08/01/11

Authorization for Self-carry/Administration of Epinephrine Auto-injector
During and After School Sponsored Activities
Hope Charter School or Legacy High School

Florida Statutes, Section 1002.20 House Bill (HB) 279 "Kelsey Ryan Act" specifies that a public school student who has life-threatening allergic reactions may carry an epinephrine auto-injector and self-administer epinephrine by auto-injector while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities if the school has been provided with parental and physician written authorization. The school principal shall be provided with a copy of the parent/physician's approval.

Student _____ DOB _____ Grade _____

School _____

Medication: Epinephrine Auto-Injector Dose _____ Administer by: Auto-Injection

Diagnosis _____ Other _____

Health condition signs/symptoms to identify _____

Duration (dates) of Administration: From _____ to _____ (Limit: One year).

I request that my child be allowed to carry/self-administer his/her Epinephrine Auto Injector medication and be responsible for its proper storage and use. I take responsibility for this permission. I understand that this medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if she/he does not, I will be contacted and we will develop a new plan.

_____ _____ _____
Parent/Guardian Date Daytime Telephone Number

I agree to terms of this contract. I will keep my Epinephrine auto injector medication in agreed location, will not share this medication with others, and will notify school authorities that I need to administer the medication.

_____ _____
Student Date

I authorize this student to carry/self-administer the above medication. He/she has been trained to recognize signs/symptoms of anaphylaxis and how to correctly use the auto-injector by me and/or my office staff.

_____
Physician's Name/Stamp

_____ _____
Physician's Signature Date

☐ Extra epinephrine auto-injector in Clinic/Health Room ☐ Original in Clinic/Health Room ☐ Copy to Student

Rev.080111

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

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs.

Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

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

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

⇩ ⇩ ⇩

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

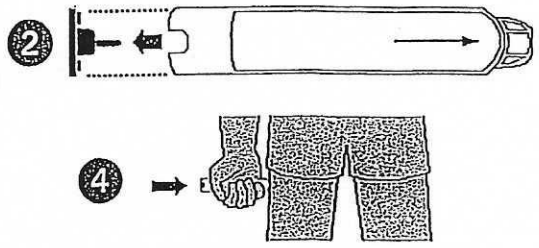
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

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

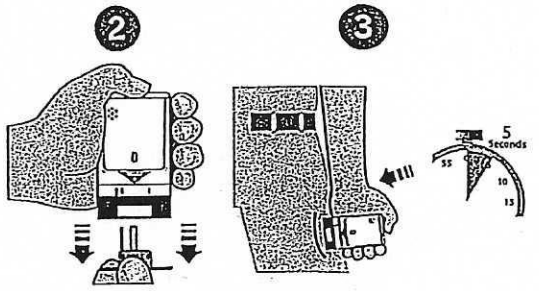
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



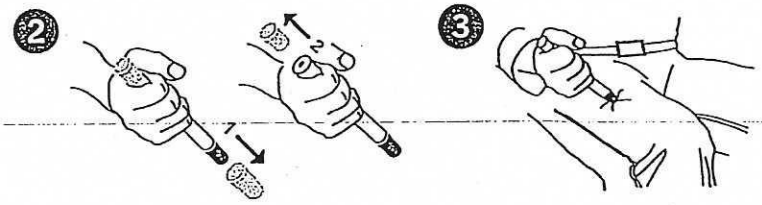
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



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

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

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