LOWNDES COUNTY SCHOOL DISTRICT
Medication Authorization for Self-Administration

Student Name:	Date of Birth:
School:	Grade:
Mother's Name:	Phone Hm: Work/Cell:
Father's Name:	Phone Hm: Work/Cell:
Physician's Name:	

_____This student may carry and self-administer the following medications at school.

_____This student may carry the following medication for administration BY school personnel.

Name of medication: _____

Dosage: _____ Time: _____

Start Date: _____ End Date: _____

Symptoms that may indicate need for medication:

_____

_____

Factors that may trigger/precipitate symptoms:

_____

_____

Specific instructions if student has symptoms:

_____

_____

PHYSICIAN APPROVAL

I agree with the above medication plan, including the name, purpose, dosage and administration directions of the medication.

It is my professional opinion that this student should be permitted to carry and self-administer this medication.

_____

Physicians Signature Date

PARENTAL CONSENT & RESPONSIBILITIES

I, the parent/guardian of the above named child, understand and agree to the conditions of the school policy on medication administration. I permit the school to seek emergency medical treatment for my child when deemed necessary and appropriate. I give authorization for self– administration and possession of the named medication by my child while at school, at school-sponsored activities, while under the supervision of school personnel and while in before-or after-school care on the school property. My child demonstrates a full understanding of the proper use of this medication.

I am responsible for: (1) Monitoring the medication, medication use, and supplying the medication. (2) Ensuring my child always carries this medication on his/her person. (3) Deciding if back-up medication will be kept at school, and providing the school with back-up medication. (4) Informing the school in writing of any changes in treatment or medical condition of my child. (5) Informing the school of any medication side effects of which I should be notified.

I consent for the physician to release information about my child related to this medication to the school nurse.

I release Lowndes County School District its employees of any legal responsibility related to my child's possession and self-administration of this medication.

_____

Parent/Guardian Signature Date

STUDENT AGREEMENT: I understand and agree to follow the Lowndes County School District's policy for self-administration of my medication while ate school. I have been instructed in the proper use of this medication. I will be responsible for carrying the medication and will not allow another student to use my medication under any circumstances.

_____

Student Signature Date

Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪ If a food allergen has been 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 ☐ Antihistamine
▪ Heart†	Weak or 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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr._____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a._____	1.)_____	2.)_____
b._____	1.)_____	2.)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)