Dear Parent/Guardian:

To insure the best safety for your child while in school, ALL medications must be brought into school by an adult by the first day of school.

Please bring in the completed required physician and parent/ guardian medical forms along with the medication in the original pharmacy container.

Thank you for your cooperation.

School Nurse

MEDICATION ADMINISTRATION IN SCHOOLS

The following rules for the administration of medication in schools applies to BOTH prescription and non-prescription (e.g., Tylenol, cough syrup) medications in the school setting. No medication will be administered unless the following requirements are me:

1. A written order from the physician to include the name of the pupil, name of the medication, dosage, the time the medication is to be administered at school and length of time to be given.
2. A written medication administration form completed by the parent/guardian releasing the school and the school personnel from any liability thereof. Medications are administered by a school nurse or designated responsible person. Medication Administration forms are available at the school office and from the school nurse.
3. Medications are to be delivered to the school by the parent/guardian or a designated responsible person.
4. All medication must be in the original container and clearly labeled.
5. Controlled medications (e.g. Ritalin) require a thirty-day physician's renewal.
6. At the end of the school year, medications must be picked up at school by the parent/guardian. Any remaining medication will be destroyed.
7. If self-administration of a medication is prescribed, the parent/guardian and the authorizing physician must complete the medication administration form.

School personnel <u>shall not</u> provide pupils with any medication until all the requirements are met.

Parent

SCHOOL NURSE PROGRAM
Camden County Non-Public Schools

PARENT PERMISSION FORM for DELEGATING EPI-PEN ADMINISTRATION

Student Name _____ D.O.B._____

I give permission for the school nurse or her trained delegate to administer an Epi-pen or an Epi-pen jr. to my child _____, for the treatment of anaphylaxis as identified by my child's doctor. I understand that if the school nurse is not available, a trained delegate will administer the Epi-pen. I also realize that if for some reason, neither the school nurse nor the trained delegate is available, 911 will be called.

I acknowledge that if the established protocols are followed, the Camden County Health Department, _____School and its employees shall have no liability as a result of any injury arising from the administration of the Epi-pen to my child. I indemnify and hold harmless the school and its employees or agents against any claim arising out of the administration of the Epi-pen to my child.

I also understand that this permission is effective for this school year only, and must be renewed for each subsequent school year.

Name of Delegate: _____

Parent's Signature: _____ Date: _____

Epi-2

Doctor

PHYSICIAN'S PERMISSION
for Delegating Administration of
Epi-Pen When School Nurse Is Not Present

Student's Name:_____ DOB_____

Anaphylactic allergy to:

- ☐ Insect stings such as bees or wasps _____
- ☐ Exposure to the following allergen _____
- ☐ Food allergy to _____

This student may experience a life threatening reaction to the allergens listed above, and does not have the ability to self-administer an injection of epinephrine. I understand that when the school nurse is not available, a trained delegate will administer the Epi-pen or Epi-pen Jr. I also understand that if the school nurse or the trained delegate is not available, 911 will be called.

If there is reasonable suspicion that the above named child has been stung or has ingested the above named allergen, or if any of the following signs of anaphylaxis develop, I give my permission for the trained delegate to follow this protocol. Signs of an anaphylactic reaction include: itching or swelling of the lips, tongue, or mouth; itching or tightness in the throat, hoarseness; hives, itchy rash, and swelling of the face or extremities; nausea, abdominal cramps, vomiting, diarrhea; shortness of breath, wheezing or hacking cough; thready pulse or passing out.

1. Administer immediately: ___ Epi-pen (.3mg)
   ___ Epi-pen Jr. (.15mg)
2. Call 911 and parent immediately.
3. Begin CPR if pulse or breathing is absent.
4. Make child as comfortable as possible until the ambulance arrives.

_____ _____

Physician's Signature Date

Office stamp:

*Please note that the NJ. State Law PL 1997, C.368 allows the delegate to administer no medications except the Epi-pen or Epi-pen Jr.

EMERGENCY HEALTH CARE PLAN - EPI 3

Doctor & parent

Student's Name_____ DOB _____ Teacher_____

Allergy to _____

Trained Delegate_____

School Nurse_____

SIGNS OF ALLERGIC REACTION INCLUDE:

Systems	Symptoms
Mouth	itching and swelling of the lips, tongue or mouth
Throat*	itching and /or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gastrointestinal	nausea, abdominal cramps, vomiting, diarrhea
Respiratory*	shortness of breath, repetitive coughing, and/or wheezing
Cardiovascular*	'thready' pulse, passing out

Specific symptoms for this student may include: _____

_____

**All above symptoms can potentially progress to a life-threatening situation.* The severity of symptoms can quickly change.

ACTION:

- ☐ If ingestion is suspected
- ☐ If stung by bee
- ☐ Experienced other life threatening allergy
  - Inject: ___ Epi Pen ___ Epi-Pen Jr. **
  - Call 911
  - Call: ___ Mother(_____) ___ Father(_____) or ___ emergency contact
  - Call: Dr._____ at _____
  - Continue to monitor student for absent breathing/pulse until EMT arrives.
  - Initiate CPR if pulse and/or breathing absent
  - Offer reassurance to student, as appropriate

*** Give used epi-pen to EMT*

_____ _____

Parent Signature Date

_____ _____

Doctor's Signature Date

MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Parent

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

Parent/Guardian Signature Date

****

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date _____

Pharmacy _____ Phone _____

Name of Medication _____

Name of Physician _____ Phone _____

Of Tablets Received _____

****

PHYSICIAN'S ORDERS

Doctor

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

_____

Doctor's Name (please print) Doctor's Signature Date

MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Parent

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

Parent/Guardian Signature Date

****

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date _____

Pharmacy _____ Phone _____

Name of Medication _____

Name of Physician _____ Phone _____

Of Tablets Received _____

****

PHYSICIAN'S ORDERS

Doctor

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

_____

Doctor's Name (please print) Doctor's Signature Date

Parent

Please Print

Name: _____ Grade: _____

Medication/Dose: _____

Purpose: _____

Emergency Contacts:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Doctor: _____ Phone: _____

Parent/Guardian Signature: _____

Medication