BASIC MEDICATION FORM

INCLUDES:

Any non-prescription medication

Examples: tylenol, ibuprophen, mydol, tums

SCHOOL MEDICATION AUTHORIZATION FORM

Date:
School:

STUDENT INFORMATION

Student:	School:	DOB:	Grade:
Parent:	Phone:	Email:	
Prescriber Name:	Phone:	Fax:	
School Nurse:	School Phone:	Fax:	

Parent: (1) Complete the above section, (2) read and sign below, (3) obtain signature from Health Care Provider (if a presciption medication), and (4) return to the school office or school nurse.

As parent/guardian I request the medication(s) listed below be given to my student during regular school hours.

☐ I understand medication will be administered by trained school employee volunteers.
☐ I understand a **new medication authorization form** will be required **each school year** and whenever there is a dosage change.
☐ I understand parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
☐ I understand that once supplied medication(s) **expire**, school staff will **not be able to administer it to student.**
☐ I understand prescription medication must be **transported** to and from school ***by an adult*.**
☐ I understand **all prescription medication(s)** must be in the current original pharmacy container and labeled, with the child's name, medication name, administration time, dosage, and health care provider's name.
☐ I understand **over-the-counter medication** must be in the **original manufacture container**.
☐ I understand the information contained in this form will be shared with school staff on a need-to-know basis.
☐ I understand it is my responsibility to **notify the school nurse of any change** in my student's health status, care or medication order(s).
☐ I understand it is my responsibility to pick up my child's unused or discontinued medication(s) **within two weeks** following the last dose administered.
☐ I understand it is my responsibility to pick up my child's medication(s) within **two weeks following the last day of school**. Medication remaining after this time will be **destroyed** according to directives by the District School Nurse.

I give permission for the School Nurse to contact the healthcare provider if clarification is needed for administering of the medication(s) below.

Parent Signature: _____ Date: _____

MEDICATION INFORMATION

Name of Medication	Indication/Diagnosis	Dosage	Route	Time	Side Effects

Additional Instructions to the School:

Medication Will be Kept:

☐ In the office ☐ Student Self-Carries* ☐ Other:_____

*Student may self-carry medication in certain circumstances (see school policies). If a student qualifies to self-carry medication, supplemental forms need to be completed and turned into the school. *School Administrators have the final say on whether medication can be self-carried.*

HEALTH CARE PROVIDER AUTHORIZATION

*~**If medication above is a prescription medication**, this form must be signed by the Provider prescribing to be valid, and can only be signed by an MD/DO: Nurse Practitioner, Certified Physician's Assistant, or a provider with prescriptive practice.~*

The above named student is under my care. It is medically necessary that this student has available the above prescribed medication(s) while under the control of the school.

Prescribing Provider (Printed):	Office Phone #:
Prescribing Provider's Signature:	Date:

ASTHMA MEDICATION FORM

Includes:

INHALERS

Asthma Action Plan (AAP)

Medication Authorization & Self-Administration Form

in accordance with UCA 53G-9-503

Utah Department of Health/Utah State Office of Education

School Year:

Picture

STUDENT INFORMATION

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax or email:
School Nurse:	School Phone:		Fax or email:

History of anaphylaxis where epinephrine was used?

☐ Yes (please also complete anaphylaxis EAP)--allergy to:_____ ☐ No

PHYSICIAN TO COMPLETE

Green Zone: Doing Great!

Student has ALL of these:

- Breathing is easy
- No cough or wheeze
- Can sleep all night
- Able to work and play normally

Controller (preventive) medications **taken at home**:

Medication:_____ Dose:_____ When:_____

Medication:_____ Dose:_____ When:_____

Medication:_____ Dose:_____ When:_____

Asthma triggers include: ☐Dust ☐Pet dander ☐Colds ☐Tobacco smoke ☐Mold ☐Exercise ☐Strong odors ☐Pollen ☐Inversions

☐ Other:_____

Take quick-relief medication (see medication order in Yellow Zone):

☐ Before exercise/exposure to a trigger When: _____

☐ Other: _____ When: _____

Yellow Zone: Caution!

Student has ANY of these:

- Coughing or wheezing
- Tight chest
- Shortness of breath
- Waking up at night

Quick-relief medication with spacer (if available):

Medication	Dose	Interval
Inhaler:		
Nebulizer:		
Other:		

Possible side effects:

Parent should contact Healthcare Provider below if 1) quick-relief medication is needed more often than every 4 hours, or needed every 4 hours for more than a day or 2) there is no improvement after taking medication.

Red Zone: Emergency!

Student has ANY of these:

- Can't eat or talk well
- Breathing hard and fast
- Medicine isn't helping
- Rib or neck muscles show when breathing in

Call 911 for an ambulance or go directly to the emergency department

☐ Repeat quick-relief medication every 20 minutes until medical help arrives.

☐ *Other (specify):*

Parent should contact Healthcare Provider below while providing treatment.

CONTINUED ON NEXT PAGE →

Student Name:	**DOB:**

PRESCRIBER TO COMPLETE

The above named student is under my care. The above reflects my plan of care for the above named student.

☐ **It is** medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times.

☐ **It is not** medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.

Prescriber Name:	Phone:
Prescriber Signature:	Date:

PARENT TO COMPLETE

Parental Responsibilities:

• The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.

• The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.

• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before the designated staff can administer the updated asthma medication prescription.

Parent/Guardian Authorization

☐ **I authorize** my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others.

☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

☐ **I authorize** the appropriate/designated school personnel maintain my child's medication for use in emergency.

Parent Signature:	Date:

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and held harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the asthma action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE (or principal designee if no school nurse)

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication log generated

Inhaler is kept: ☐Student Carries ☐Backpack ☐In Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):

Asthma Action Plan distributed to 'need to know' staff:
☐ Teacher(s) ☐ PE teacher(s) ☐ Transportation ☐ Front Office/Admin ☐Other (specify):

School Nurse Signature:	Date:

DIABETES MEDICATION FORM

Includes:

GLUCAGON + INSULIN

Diabetes Medication Management Orders (DMMO) In Accordance with UCA 53G-9-504 and 53G-9-506 Utah Department of Health/Utah State Board of Education	PCH Outpatient Diabetes Program (801) 213-3599 Fax (801) 587-7539	Other Provider (LIP)

STUDENT INFORMATION	School Year:	
Student Name:	☐ Type 1 ☐ Type 2	Name of School:
DOB:	Age at diagnosis:	School Fax:

In accordance with these orders, an Individualized Healthcare Plan (IHP) must be developed by the School Nurse, Student, and Parent to be shared with appropriate school personnel, *and cannot be shared with any individual outside of those public education employees without parental consent.* As the student's Licensed Independent Provider (LIP), I confirm the student has a diagnosis of diabetes mellitus and it is 'medically appropriate for the student to possess and self-administer diabetes medication and the student should be in possession of diabetes medications at all times'. Per my assessment, I recommend:

☐ Student is capable to carbohydrate count meals and snacks for insulin adjustment, carry, and self-administer diabetes medication/insulin.

☐ Student requires a trained adult to supervise carbohydrate counting of meals and snacks for insulin adjustment and self-administration of diabetes medication/insulin.

☐ Student requires a trained adult to carbohydrate count meals and snacks, for insulin calculation, and administer diabetes medication/insulin during periods the student is under the control of the school.

☐ This student may participate in ALL school activities, including sports and field trips, without restriction.

☐ This student may participate in school activities with the following restrictions:

EMERGENCY GLUCAGON ADMINISTRATION Immediately for severe hypoglycemia: unconscious, semiconscious (unable to control airway, or seizing	Glucagon Dose: 1.0 mg/1.0 ml	Route: IM	Possible side effects: Nausea and Vomiting

BLOOD GLUCOSE TESTING Target range for blood glucose (BG): ☐100-200 ☐80-150 ☐Other:

Times to test: ☐Before meals ☐Before exercise ☐After exercise ☐Before going home

☐If symptomatic (See student's specific symptoms in Individualized Healthcare Plan (IHP).

- If BG is less than ____ mg/dl, follow management per Diabetes Emergency Action Plan (EAP).
- Student should not exercise if BG is below ____ mg/dl or symptomatic of hyperglycemia.

SNACKS ☐15 gram carb snack at ___ AM ☐ 15 gram carb snack at ____ PM ☐No routine snacks at school
☐15 gram carb snack before PE/Recess ☐'Free' snacks (no insulin coverage) ☐Other:

INSULIN ADMINISTRATION	☐Humalog ☐Novolog ☐Apidra ☐Other:	☐Insulin vial/syringe ☐Insulin pen ☐Insulin pump	Route: Subcutaneous	Possible side effects: Hypoglycemia

Insulin to Carbohydrate (I:C): ___ units for every ___ grams of carbohydrate before food.	Correction Dose (can only be administered at meal times):___ unit for every ____ mg/dl for blood glucose above ___mg/dl.

SNACKS/PARTIES: ☐Snacks/parties (use I:C ratio) ☐No coverage for snacks/parties ☐Other:

INSULIN PUMP: If using insulin pump, carbohydrate ratio and correction dose are calculated by pump. Correction doses at times other than meals per PUMP calculation ONLY.

ADDITIONAL PUMP ORDERS: Student may be disconnected from pump for a maximum of 60 minutes, or per IHP/EAP. If unable to use pump after 60 minutes contact parent/guardian, and if BG is over 250 mg/dl give correction dose via syringe or pen. If able to reconnect pump, administer correction dose as calculated by pump.

→

Student Name:	DOB:

CONTINUOUS GLUCOSE MONITORING (CGM)

All students using a CGM at school must have the ability to check a finger stick blood glucose with a meter in the event of a CGM failure or apparent discrepancy.

☐ None

☐ Dexcom G4 is **not** FDA approved for making treatment decisions. When the CGM alarms, treatment should be determined based on a finger stick blood glucose.

☐ Dexcom G5 **is** FDA approved for making treatment decisions. Correction doses of insulin for hyperglycemia, or the intake of carbohydrates for treating hypoglycemia can be determined at school based on the CGM is the sensor glucose value is between 80 mg/dl and 350 mg/dl and there is a directional arrow; unless otherwise directed by the provider. If the symptoms of the student don't match the CGM reading, check a finger stick blood glucose with a meter. In addition, the parent/guardian must sign below verifying they are responsible for calibrating the CGM at home two times daily and approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the CGM.
Parent Signature:_____

☐ Dexcom G6 **is** FDA approved for making treatment decisions. Correction doses of insulin for hyperglycemia, or the intake of carbohydrates for treating or preventing hypoglycemia can be determined at school based on the CGM if there is a glucose number and a directional arrow visible on the CGM. The "Urgent Low Soon Alert" signifies that a glucose of 55 mg/dl will be reached within 20 minutes. This should be treated based on the student's hypoglycemia treatment plan. If the symptoms of the student don't match the CGM reading, check a finger stick blood glucose with a meter. In addition, the parent/guardian must sign below verifying they approve the school personnel or school nurse to treat hypoglycemia or give insulin doses based on the CGM.
Parent Signature:_____

☐ Medtronic 530 G and 630 G with Enlite Sensor, and 670 G with Guardian sensor are **not** FDA approved for making treatment decisions. When CGM alarms, treatment should be determined based on a finger stick blood glucose. If the pump requests a calibration, the student can calibrate this on their own. The school nurse and the parent must put a plan in place for calibrating the CGM at school if the pump request a calibration and the student is unable to calibrate the CGM independently. The reading used to calibrate the CGM must come from a finger stick blood glucose using a meter. In addition, the parent/guardian must sign below verifying they approve the school personnel or school nurse to assist with calibrations (if desired).
Parent Signature:_____

☐ Frestyle Libre is **not** FDA approved for making treatment decisions in individuals under the age of 18.

ADDITIONAL ORDERS:

☐None

☐Student to go to office for adult supervision of BG testing and insulin administration

TO BE COMPLETED BY PARENT OR GUARDIAN

I understand that a school team, including parent or guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendation, available resources, and the student's level of self-management. I acknowledge that these orders signed by the LIP will be used by the school nurse, and shared with appropriate school staff, to develop the IHP for my child's diabetes management at school. I understand and accept the risk that in the course of communication between myself, the school, and the provider, protected health information (PHI) sent via unencrypted email or text message may be intercepted and read by third parties.

Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
Prescriber Name (print):	Phone:	
Prescriber Signature:	Date:	

ALLERGY MEDICATION FORM

Includes:

EPIPEN + AUVI-Q

ALLERGY & ANAPHYLAXIS - EMERGENCY ACTION PLAN (EAP)

Allergy Medication Authorization & Epinephrine Auto-Injector Authorization (EAI) Self-Administration Form

Utah Department of Health, In Accordance with UCA 26-41-104

School Year:

Picture

STUDENT INFORMATION

Asthma: ☐ No
☐ Yes (if yes, high risk for severe reaction, please also complete Asthma Action Plan)

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax or email:
School Nurse:	School Phone:		Fax or email:

EXTREMELY REACTIVE TO THE FOLLOWING:

Allergen(s):

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

☐ peanuts	☐ wheat	☐ latex	☐ other (specify):
☐ tree nuts	☐ eggs (safe to have in baked goods)	☐ animals	
☐ soy	☐ dairy (safe to have in baked goods)	☐ medication	
☐ fish	☐ dairy (NOT safe to have in baked goods)	☐ insect stings (specify):	
☐ shellfish	☐ eggs (NOT safe to have baked goods)		

ACTIONS FOR MILD TO MODERATE ALLERGIC REACTION

MILD Symptoms

Nose – itchy/runny nose
Mouth- Itchy mouth
Skin – A few hives, mild itch
Gut – Mild nausea/discomfort, one episode of mild vomiting (not repetitive)

For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

For MILD SYMPTOMS from MORE THAN ONE system area, GIVE EPINEPHRINE

ACTION FOR SEVERE ALLERGIC REACTION (ANAPHYLAXIS)

SEVERE Symptoms

Lung-short of breath, wheezing, repetitive cough
Heart-pale, blue, faint, weak pulse, dizzy
Throat-tight, hoarse, trouble breathing or swallowing
Mouth-significant swelling of the tongue and/or lips
Skin-Many hives over body, widespread redness
Gut-Repetitive vomiting, severe diarrhea
Other-Feeling something bad is about to happen, anxiety, confusion

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
3. Consider giving additional medications <u>following epinephrine</u>
   - Antihistamine
   - Inhaler (bronchodilator) if wheezing
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
6. Alert emergency contacts.
7. Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return.

CONTINUED ON NEXT PAGE ⟶

Student Name:		**DOB:**
MEDICATION		
Epinephrine (EAI) Brand:	Epinephrine Dose: ☐0.15 mg IM ☐0.3 mg IM	Side Effects:
Antihistamine Name:	Dose:	Side Effects:
Other: (e.g., inhaler-bronchodilator of wheezing)	Other Dose:	Side Effects:
☐Student Carries ☐Backpack ☐In Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):		
PRESCRIBER TO COMPLETE		
The above named student is under my care. The above reflects my plan of care for the above named student. ☐ **It is** medically appropriate for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times. ☐ Student can self-carry and self-administer EAI if needed, when able and appropriate. ☐ Student can self-carry, but not self-administer EAI. ☐ **It is not** medically appropriate to carry and self-administer this EAI medication. Please have the appropriate/designated school personnel maintain this student's medication for use in an emergency.		
Prescriber Name:		Phone:
Prescriber Signature:		Date:
PARENT TO COMPLETE		
Parental Responsibilities: • The parent or guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name. • The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given. • If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form/Emergency Action Plan (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.		
Parent/Guardian Authorization ☐ **I authorize** my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.	☐ I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate. ☐ I authorize my student to self-carry, but not self-administer EAI.	
☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency		
Parent Signature:	Date:	
As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this Emergency Care Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following physician instruction as written in the emergency action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.		
Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
SCHOOL NURSE (or principal designee if no school nurse)		
☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication Log generated
EAI is kept: ☐Student Carries ☐Backpack ☐Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):		
Allergy & Anaphylaxis EAP distributed to 'need to know' staff: ☐ Front office/administration ☐ PE teacher(s) ☐ Teacher(s) ☐ Transportation ☐ Other (specify):		
School Nurse Signature:	Date:	

SEIZURE MEDICATION FORM

SEIZURE Medication/Management Orders (SMMO) Utah Department of Health/Utah State Board of Education In Accordance with UCA 53A-11-603.5	PCH Pediatric Neurology Clinic 801-213-3599 Fax: 801-587-7539	Other provider:

STUDENT INFORMATION			
Student:	**DOB:**	**Grade:**	**School:**
Parent:	**Phone:**		**Email:**
Physician:	**Phone:**		**Fax:**
School Nurse:	**School Phone:**		**Fax:**

SEIZURE INFORMATION		
Seizure Type/Description	**Length**	**Frequency**

If Seizures are full body tonic-clonic, rescue medication may be administered by a trained volunteer.
Seizures other than tonic-clonic, rescue medication can only be given by an RN, Parent or EMS.

☐ Yes ☐ No Student has received a first dose of this medication in a non-medically-supervised setting without a complication.

If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.

☐ Yes ☐ No Student has previously ceased having a full body prolonged or convulsive seizure as a result of receiving this medication.

If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider, and return to school nurse.

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order. I understand the information contained in this order will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature:	Date:

CONTINUED ON NEXT PAGE →

Student Name:	DOB:

EMERGENCY SEIZURE RESCUE MEDICATION

To Be Completed by Prescriber - In accordance with these orders, an Individualized Health Care Plan (IHP) must be developed by the School Nurse and parent to be shared with appropriate school personnel, *and cannot be shared with any individual outside of those public education employees without parental consent*. As the student's LIP I confirm that the student has a diagnosis of seizures.

Give Emergency Medication IF:	**Medication**	**Dose**	**Route**	**Call**
• If seizure lasts ___ minutes or greater • If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes) • Other_____	□ Midazolam (Versed) (Dose must be provided in 2 syringes) □ Diazepam (Diastat) □ Other _____	_____ mg _____ ml	□ Nasal □ Rectal □ Other	**ALWAYS call 911, parent and School Nurse**

☐ This medication is necessary during the school day. Trained personnel should and will be allowed to administer this medication.

Common potential side effects: respiratory depression, nasal irritation, memory loss, drowsiness, other:

Additional instructions for administration:

VAGUS NERVE STIMULATOR

☐ This student has a Vagus Nerve Stimulator. Trained personnel should and will be trained on magnet use. Describe magnet use:

PRESCRIBER SIGNATURE

This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

Prescriber Name:	Phone:
Prescriber Signature:	Date:
School Nurse Signature:	Date: