Notre Dame Academy
312 First St. Palisades Park, NJ 07650
Tel: (201) 947-5262 Fax: (201) 947-8319
www.ndapalpark.org

Medication Administration at School

The following is the policy of Notre Dame Academy regarding the administration of medication to pupils at school:

Staff members are not to give or administer medication to students at any time. All medication for students are to be administered by the school nurse in accordance with the following procedures and regulations established by the Board of Education.

Medications will be administered to students after the following criteria are met:

1. A written statement has been received from the parents authorizing the administration of the medication prescribed by the family physician together with a written statement from said family physician, which identifies the type, dosage, and purpose of the medication. **This statement shall be required, and there will be no deviation from this requirement.**
2. All statements and medications are to be given directly by the school nurse or to the principal. Medications MUST be in a labeled pharmacy bottle that identifies the pupil, the medication, and prescribed dosage. Medications will be kept under lock and key in the nurse's office.
3. **No medication, including over-the-counter medications, can be administered without a specific order from a physician. <u>This includes Advil, Tylenol, or cough drops.</u>**
4. For students who have had a severe allergic reaction requiring the administration of Epipen injection, please refer to the nurse's allergy page for more information concerning the administration of Epipen injection at school.

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Medication Authorization Form/Allergy Action Plan

School Nurse Order

Student's Name_____**D.O.B.**_____**Teacher**_____

ALLERGY TO:_____

ASTHMATIC: Yes ☐ No ☐

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+: Thready pulse, low B/P, fainting, pale, cyanosis	☐ Epinephrine ☐ Antihistamine
• Other+: _____	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing (several of the above areas affected)	☐ Epinephrine ☐ Antihistamine

+The severity of symptoms can quickly change. **+Potentially life-threating**

DOSAGE

Epinephrine auto injector IM to mid outer thigh (Check dose) ☐ **0.3 mg** ☐ **0.15 mg**

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. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone number _____
3. Parent (home) _____ (Cell) _____
4. Emergency Contacts:

	Name and relationship	Phone numbers	
a.	_____	(1) _____	(2) _____
b.	_____	(1) _____	(2) _____

****EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, IMMEDIATELY TRANSPORT TO MEDICAL FACILITY! *****

Parent/Guardians Signature_____ Date_____

Doctor/Nurse Practitioner Signature _____ Date_____

Physician Stamp_____

School Nurse Reviewed _____ Date_____

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Child's photo

Medication Authorization Form/Allergy Action Plan
Designee order

Student's Name_____**D.O.B.**_____**Teacher**_____

Allergy to: _____

Asthmatic: Yes ☐ No ☐

STEP 1:

In the event of contact to/ingestion of an allergen or insect sting/bite *immediately* administer:

Epinephrine auto injector IM to mid outer thigh (Check dose)	☐ **0.3 mg**	☐ **0.15 mg**

STEP 2: EMERGENCY CALLS

5. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
6. Dr. _____ Phone number _____
7. Parent (home) _____ (Cell) _____
8. Emergency Contacts:

	Name and relationship	Phone numbers	
a.	_____	(1) _____	(2) _____
b.	_____	(1) _____	(2) _____

****EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, IMMEDIATELY CALL 911 AND TRANSPORT TO MEDICAL FACILITY! *****

I hereby give my consent to permit a member of the epi-pen delegate team (*list attached*) as the designated person/persons to administer epinephrine to my child in an emergency and in the absence of the school nurse.

Parent/Guardians Signature_____ Date_____

Doctor/Nurse Practitioner Signature _____ Date_____

Physician Stamp_____

School Nurse Reviewed_____ Date_____

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Parent consent for: Administration of Epinephrine

1. Medication authorization form/allergy action plan (School nurse order) _____ *(Parent Initials)*
2. Medication authorization form/allergy action plan (Designee order) _____ *(Parent Initials)*
3. Individualized Health Care Plan _____ *(Parent Initials)*

I, _____, parent/guardian of _____,
(Please Pint Name) *(Please Print Child's Name)*

have read and/or reviewed the above mentioned forms. I understand the content of each document, as indicated by my initial above. I hereby give my consent to permit:

1. **a member of the epi-pen delegate team** 2. _____
3. _____ 4. _____

as the designated person/persons to administer epinephrine to my child in an emergency and in the absence of the school nurse. The permission is effective this school year only. Permission must be renewed each subsequent year upon fulfillment of the requirements.

I agree to indemnify and hold harmless the Notre Dame Academy and its employees or agents any liability as the result of any injury arising from the administration of epinephrine to the above named student.

_____	_____	_____	_____
Parent/Guardian Name (Print)	Date	Parent/Guardian Signature	Date

Reviewed by:

_____	_____	_____	_____
School Nurse (Print)	Date	School Nurse Signature	Date

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INDEMNIFICATION / HOLD HARMLESS AGREEMENT FOR ADMINISTRATION OF MEDICATION AND/OR EPINEPHRINE

The parent(s)/guardian(s) individually, and on behalf of the pupil, agree(s) to indemnify, defend and hold Notre Dame Academy, its teachers, nurse(s), principal, and employees harmless from any and all claims, actions, costs, expenses, damages and liabilities, including attorney's fees, arising out of, connected with or resulting from the administration of medication and/or epinephrine by or to the pupil. The parent(s)/guardian(s) individually and on behalf of the pupil agree(s) that Notre Dame Academy, its teachers, nurse(s), and employees shall incur no liability as a result of any injury, damages or expenses arising out of or connected with the administration of medication and/or epinephrine by or to the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as permission is provided for the administration of medication and/or epinephrine.

This agreement must be signed and be in full effect prior to the granting of permission to administer medication and/or epinephrine.

Name of Student _____ Date of Birth _____

School_____

Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Date of Agreement _____

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AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

This form must be completed by the **PARENT** *or* **GUARDIAN**:

_____ _____ _____
Name of Student Date School

_____ _____ _____
Name of Physician (*Type or Print*) Full Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school, as authorized by me and by my physician. (*See Below*)

_____ _____ _____ _____
Date Signature of Parent/Guardian Home Phone Emergency Phone

The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: _____

Name of medicine: _____ Form: _____

Dose: _____

If medicine is to be given **DAILY**, at what time? _____

If medicine is to be given "**WHEN NEEDED**," describe indications: _____

_____

How soon can it be repeated? _____

List significant side effects: _____

_____

First aid, in case of adverse reactions: _____

Date prescribed: _____ Date to be discontinued: _____

Other Significant Information:

_____

_____

_____

_____ _____
Date Approved by Physician Signature of Physician

_____ _____
Date Signature of School Physician

Recommendations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school office before any medication can be administered.