Preschool As Needed Medical Forms

Dear Parents,

Attached are some commonly used clinic forms that your child may need. These forms are to be completed annually. Please be aware that most forms require a parent and licensed health care provider signature. Once the form is complete turn it in to your classroom teacher, the main office, or the clinic

Our fax number is (440)237-3308 Attn: School Clinic

If you have any questions call the clinic at (440)628-8465

PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

***** One Medication per Form *****

Student Photo

School _____.

Student _____ Grade/Rm_____

Address _____

City/State/Zip _____

Name of Medication and Dosage _____

Times of Day to be Administered_____

Number of Times/Intervals Medication is to be Administered_____

Date to Begin Medication_____ Date to End Medication_____

Adverse/Severe Reaction that Should be Reported to Physician _____

Special Instructions for Administration of Medication_____

This medication can be safely administered by non-medical personnel ☐ Yes No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours ☐ Yes No

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

_____ _____

Prescriber's Printed Name Tel

_____ _____

Prescriber's Signature Date

Please regard my signature below as my assurance that I release _____ _____School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Printed Name Tel

_____ _____

Parent's Signature Date

ASTHMA SCHOOL MEDICATION PLAN

Student Name: _____ Birthdate: _____

School Name: _____ Grade/Rm. _____

Emergency Contact Information and Parent / Guardian Information:

Parent / Guardian-1 (name / relationship): _____

Phone (H) _____ Tel (W) _____

Parent / Guardian-2 (name / relationship): _____

Phone (H) _____ Tel (W) _____

Healthcare Provider _____ Phone: _____

Asthma Specialist: _____ Phone: _____

Student Photo

Emergency contact if other than above (name/relationship): _____ Phone: _____

Diagnosis / Reason for Medication:	___Asthma ___ Other:
Asthma Triggers to Avoid for student while at school:	__Smoke / fumes __ Animal __Mold Spores __ Dust Mite Other:

YES / NO: Student is required to have quick relief asthma medication at school to provide rapid relief of asthma symptoms if needed: **cough, chest tightness, wheezing, trouble breathing, shortness of breath**

YES / NO: Student is required to use quick relief asthma medication BEFORE gym or other exercise to prevent exercise induced bronchospasm from asthma

YES / NO: Student is required to take daily asthma control medication at school as directed

Medication Information					
Name of Medication	**YES / NO: Albuterol**			**Other:**	
Form of Medication	___Inhaler	___Nebulizer	___Dry Powder Inhaler	___ Liquid	___Pill / Capsule
Dosage of Medication	Number of puffs _____		Other: _____		
Other instructions:	YES / NO: Inhaler MUST be used with a spacer (valved holding chamber) for administration YES / NO: Please maintain a written record (Log) of all doses: YES / NO				
When to administer dose	YES / NO: 5-15 minutes before gym, recess, or exercise to prevent exercise induced bronchospasm YES / NO: As needed for FAST RELIEF of chest tightness, shortness of breath, wheezing or prolonged cough or other asthma symptoms. A total of 3 doses can be given within an 8 hour interval YES / NO: Daily at _____ AM / PM for daily asthma control (long term prevention)				
Repeat Dose	_____: DO NOT REPEAT the dose _____: Repeat dose one time if symptoms **not** gone 10 minutes after first dose AND repeat dose every 3-4 hours IF symptoms RECUR during the school day				
When to call Child's Parent	If after 2 consecutive doses (2-4 puffs per dose) are given and there is no improvement in symptoms, please seek further medical attention and call parent				
When to call Child's Physician	If you have concerns or questions about the student's medication or disease				
Asthma Emergency The steps that should be taken: •Activate the emergency medical system in your area. Call 911. •Call Parent/Guardian and/or Healthcare Provider	The following are possible signs of an asthma emergency: •Difficulty breathing, walking, or talking •Blue or gray discoloration of the lips or fingernails •Failure of medication to reduce worsening symptoms.				

Supervision of Medication	____ Student is permitted to carry medication and self-administer with no supervision ____ Student MAY self-administer medication BUT supervision is required for all doses ____ Student requires trained assistance to administer all doses		
Expected Normal side effects:	___None	___Fast heartbeat, tremor, hyper-activity	Other:
Storage Requirements	___None	___Refrigerate	Other
START Date to begin Medication	___When school receives form		Other:
STOP Date to discontinue Medication	End of school year		Other:
Instructions for proper use of medicine are attached to this form	___YES	___NO	

PLEASE COMPLETE SECTION BELOW FOR STUDENT PERMISSION TO CARRY INHALER

**********SELF-MEDICATION FOR ASTHMA INHALERS**********

Authorization (In accordance with ORC 3313.716/3313.14)

Who keeps the bronchodilator inhaler at school?

School policy restricting possession of medication by students is insufficient grounds for preventing students with sufficient maturity from retaining possession of their bronchodilator inhaler. Such policies, when enforced, delay appropriate treatment and restrict activities unnecessarily. The decision regarding sufficient maturity of the student to be responsible for appropriate inhaler use is an individual one to be made by the parents in consultation with their physician. The inhalers pose no abuse potential or other danger to classmates. While restrictions on bronchodilator inhaler possession may be necessary for the youngest students, it constitutes unreasonable interference with the student's medical care for school personnel to unilaterally restrict possession of bronchodilator inhalers by students judged by parents and physician to have sufficient maturity to use the device appropriately. Possession of the bronchodilator inhaler by the student also promotes earlier use that decreases the risk of requiring emergency care from rapidly progressive asthma, which on rare occasion can cause hypoxia, brain damage, and death. Discussion among parents, physician, and school personnel can determine whether school-supervised administration would improve or deter compliance.

_____ **Please check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF-MEDICATE at school.**

Student Agreement and Signature:

I, _____, agree that I will:

Never allow another student to use my medication.

Keep my medication with me at all times.

Go to the School Clinic, accompanied by someone, when I used my rescue inhaler and continue to have symptoms.

Follow school policy and my medical provider's instructions as outlined in my Asthma Medication Plan.

Student Signature:_____ **Date:**_____

****

Signature of Parent/Guardian _____ Date _____

Signature of Prescriber _____ **Date** _____

Copies must be provided to the principal and to the nurse.

University Hospitals Rainbow Babies & Children's

**********SELF-MEDICATION FOR ASTHMA INHALERS**********

(In accordance with ORC 3313.716/3313.14)

Adverse reactions that should be reported to physician:

- Chest pain.
- Rash, hives, or itching.
- Fast, pounding, or irregular heartbeat.
- Swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs.
- Difficulty swallowing.
- Worsened breathing.
- Hoarseness.

Adverse reactions for unauthorized user:

- Racing heart beat
- Feeling very shaky

In the event that medication does not produce the expected relief from student's asthma attack, follow the "Steps for an Acute Asthma Episode" (on first page)

Other special instructions:

Copies must be provided to the principal and to the nurse.

Reviewed by Dr. Carly Wilbur

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ALLERGY ACTION PLAN

University Hospitals Rainbow Babies & Children's

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student Photo

Student_____School_____.

DOB_____Age_____Weight_____Grade/Rm_____

Allergy to _____

START DATE:_____ **END DATE:**_____

Student has asthma.	❑ Yes	❑ No (If yes, higher chance of severe reaction)
Student has had anaphylaxis.	❑ Yes	❑ No
Student may carry epinephrine.	❑ Yes	❑ No (if yes, complete next page)
Student may give him/herself medicine.	❑ Yes	❑ No (If student refuses/is unable to self-treat, an adult must give medicine.)

IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis **What to look for** If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.** ☐ Shortness of breath, wheezing, or coughing ☐ Skin color is pale or has a bluish color ☐ Weak pulse ☐ Fainting or dizziness ☐ Tight or hoarse throat ☐ Trouble breathing or swallowing ☐ Swelling of lips or tongue that bother breathing ☐ Vomiting or diarrhea (if severe or combined with other symptoms) ☐ Many hives or redness over body ☐ Feeling of "doom," confusion, altered consciousness, or agitation ❑ ***SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.***	**Give epinephrine!** **What to do** 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. ☐ Ask for ambulance with epinephrine. ☐ Tell rescue squad when epinephrine was given. 3. Stay with child and: ☐ Call parents and child's doctor. ☐ Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. ☐ Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. ☐ Antihistamine ☐ Inhaler/bronchodilator
For Mild Allergic Reaction **What to look for** If child has had any mild symptoms, **monitor child.** Symptoms may include: ☐ Itchy nose, sneezing, itchy mouth ☐ A few hives ☐ Mild stomach nausea or discomfort	**Monitor child** **What to do** Stay with child and: ☐ Watch child closely. ☐ Give antihistamine (if prescribed). ☐ Call parents and child's doctor. ☐ If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")

Medication/Doses

Epinephrine autoinjector, intramuscular (list type):_____Dose:❑ 0.15 mg ❑ 0.30 mg

Antihistamine, by mouth (type and dose): _____

Other (for example, inhaler/bronchodilator if student has asthma):_____

_____ _____ _____ _____

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Emergency Contacts/Relationship Telephone number

1._____ _____

2._____ _____

3._____ _____

******(To be completed ONLY if student will be carrying an Epinephrine Autoinjector)******

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with ORC 3313.718/8313.141)

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is not prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07

LETTER TO PRESCHOOL PARENTS/GUARDIANS
INFLUENZA VACCINE

TO: Parents/Guardians

FROM: School Health Clinic

DATE: _____

SUBJECT: Influenza Vaccine

Dear Parents/Guardians,

The Ohio Department of Health recently revised the School Immunization Requirements for Preschool Students to include an annual Influenza Vaccine (beginning the 2015-2016 school year and every year thereafter).

If your child has received the Influenza Vaccine, please provide the date the vaccine was received below.

If your child will be receiving the vaccine please indicate below and provide the date that it was received to the school after it has been given.

If you are declining to have your child receive the influenza vaccine, please indicate below.

STUDENT NAME _____

- ☐ My child had the Influenza vaccine on _____ (OR)
- ☐ My child will receive the Influenza vaccine this school year and I will provide the date to the clinic staff once it has been received (OR)
- ☐ I have declined to have my child immunized against Influenza this school year. (You must provide a signature below to indicate that you have declined.)

_____
Parent/Guardian Signature

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional
Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

STATE OF OHIO
LEGAL IMMUNIZATION EXEMPTION
Per OHIO STATUTE 3313.671 (Exemptions)
Religious, Good Cause and Medical Exemption form
Ohio revised Code Section 3313.671 Part B 1-5

3313.671 Proof of required immunizations - exceptions.

(B) (1) A pupil who has had natural rubeola, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against rubeola.

(B) (2) A pupil who has had natural mumps, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against mumps.

(B) (3) A pupil who has had natural chicken pox, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against chicken pox.

(B) (4) A pupil who presents a written statement of the pupil's parent or guardian in which the parent or guardian declines to have the pupil immunized for reasons of conscience, including religious convictions, is not required to be immunized.

(B) (5) A child whose physician certifies in writing that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

I understand that the Law permits me to sign a waiver to my child receiving vaccinations.

I hereby object and request the school to waive the proof of vaccination of my child against some or all of the following:

Mumps	**Poliomyelitis**	**Rubeola (Measles)**	**Rubella**
Diphtheria	**Pertussis**	**Tetanus**	**Hepatitis B**
Chicken Pox	**Hib**	**Other_____**	

Child's Name:_____

□ Religious: If desired, attach a page with religious statement or a letter from your religious leader.

□ Good Cause: If desired, attach another page with reason(s)

□ Medical Reason: You must have a signed statement from your physician stating the condition and attach it to this form.

I further understand that during the course of an outbreak of any of the aforementioned vaccine preventable diseases, that the student named here is subject to exclusion from school for the duration of the outbreak.

Parent/Guardian Signature:_____

Address:_____ Date:_____