Medication Administration Checklist

School Year 2020-2021

- ○ Forms must be completed in its entirety/all **signature required**
  Formas deben estar completadas en su totalidad/ todas las firmas son requeridas
- ○ Only **one medication** per form
  Solo un medicamento por forma
- ○ A student **picture** must be attached
  Una foto del estudiante tiene que estar adjunta
- ○ No faxed copies allowed for any forms, only **original forms**
  No aceptamos copias de fax, solo la forma original
- ○ **No white out** allowed on any forms
  No aceptamos formas con correcciones
- ○ New paperwork per school year
  Nuevas formas necesitan ser completadas cada curso escolar
- ○ New authorization for medication form needed for change of dose or medication
  Nueva autorizacion de medicamento es necesaria si hay un cambio de dosis o medicamento
- ○ Medication must be kept in its **original container** with **pharmacy label**
  Medicamento tiene que estar en su paquete original con la etiqueta de la farmacia

Thank you,
School Nurses

AUTHORIZATION FOR MEDICATION

ONE MEDICATION PER FORM

SCHOOL YEAR: 20__20__20__21__

STUDENT'S PICTURE

Student's Name _____ Date of Birth _____ Grade _____

School Name _____ Phone Number _____ Fax Number _____

TREATMENT PLAN (To be completed by Medical Provider)

Diagnosis: _____

ALLERGIES: _____

Medication/Strength/Route: _____

Dose & Frequency: _____

Directions: _____

_____

Side Effects: _____

Has student been trained in the use_____ (medication's name) Yes ☐ No ☐

Is student authorized to carry *and* self-administer_____ (medication's name) Yes ☐ No ☐

I am aware that this medication may be administered by school personnel/non-medical staff.

Provider's Name (PLEASE PRINT/STAMP) _____ Signature _____ Date _____

Address _____ Phone _____ Fax _____

PARENTAL/GUARDIAN PERMISSION

I, _____, give my permission to the School Principal or his/her specified
Parent/Guardian Name (PLEASE PRINT)

delegated personnel to administer prescribed medication to: _____.
(Student's name and Relationship)

Signature of Parent/Guardian _____ Phone _____ Date _____

Place Student's Picture Here

SEVERE **ALLERGY** ACTION PLAN
FOR SCHOOL PERSONNEL

Student: _____ Grade: _____ DOB: _____
Teacher: _____ Classroom: _____ SCHOOL YEAR: 2020-2021

SEVERE ALLERGY TO: _____

Asthmatic: **YES** ☐* **NO**☐ * Higher risk for severe reaction

STEP 1: RECOGNIZE THE SYMPTOMS

If _____ shows **the following symptoms as check by doctor:**

Symptoms: (Doctor, please select by checking all symptoms that require Epinephrine Auto-Injector administration)

- ☐ **Mouth** itching, tingling or swelling of the lips, tongue, mouth
- ☐ **Throat** tightening of throat, hoarseness, hacking cough
- ☐ **Skin** hives, itchy rash, swelling of the face or extremities
- ☐ **Gut** nausea, abdominal cramps, vomiting, and diarrhea
- ☐ **Lung** shortness or breath, repetitive coughing, wheezing
- ☐ **Heart** weak or thready pulse, low blood pressure, fainting, pale, blueness
- ☐ **Other** _____

STEP 2: RESPOND

Give Epinephrine Auto-Injector as directed per Authorization for Medication Form.

(Doctor, please select by checking dosage to be administered)

☐ **Epinephrine Auto-Injector** (0.15mg epinephrine)
OR
☐ **Epinephrine Auto-Injector** (0.3mg epinephrine)

Administer rescue breathing or CPR, if necessary.

STEP 3: EMERGENCY CALLS

1. **Call 911**
2. **Call Emergency Contacts**:

Name/Relationship	Phone Number	Alternate Phone Number
1.	1.	1.
2.	2.	2.
3.	3.	3.

_____ _____ _____ _____
Doctor Signature **Date** **Parent/Guardian Signature** **Date**

Department of Food and Nutrition

Diet Prescription for Meals at School

Part I (to be filled out by parent or guardian)

Name of Student: _____ Date of Birth: _____ Age: _____
(Last) *(First)* *(MI)*

School: _____

Name of Parent/Guardian(s): _____

Parent/Guardian(s) Daytime Phone No.: _____ _____ _____
Parent/Guardian's Signature

Part II (to be filled out by the physician)

Name of Student _____ requires special meals at school.

Patient´s diagnosis: _____

Brief description of patient´s condition related to the meal for diet modification: _____

_____

_____

_____

_____

Diet Prescription (check all that apply)

☐ Texture Modification:

- ☐ Pureed
- ☐ Ground
- ☐ Chopped

Foods Omitted and Substitutions (please check specific foods to be omitted and suggest substitution).

☐ Nuts	☐ Milk	☐ Wheat	☐ Peanuts	☐ Fish	☐ Mollusks
☐ Eggs	☐ Soybean	☐ Cheese	☐ Chicken	☐ Shellfish	☐ Other: _____

Specific Food Substitution: _____

_____

_____

_____

_____

I certify the above named student needs special school meals prepared as described above because of the student´s disability or chronic medical condition.

_____ _____ _____ _____
Physician´s Name (please print) Physician´s Signature Office Phone No. Date

This form is valid for up to one year from evaluation date, but may be updated as determined by the physician.

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT-SEVERE ALLERGY

Student: _____ DOB_____ Teacher: _____ Grade: _____
School: _____Parent/Guardian & Phone(s): _____
Physician & Phone: _____ School Year: 20**20**-20**21**
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has allergies or a severe allergy. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

_____ _____ _____
School Nurse Phone number Date

1. What is your child allergic to? (Circle all that apply)
Insect bites- bees, wasps, hornets, yellow jackets, fire ants, mosquitoes, spiders, other: _____
Foods- peanuts, all nuts, milk, all dairy, eggs, wheat, soy, chocolate, mango, shellfish, fish, other: _____
Latex rubber and/or any Medications (list) _____
Other Allergen- pollen, dust, smoke, animal dander, chemical fumes, other: _____
2. How many times has your child had an allergic reaction? □Once □ 2-3 times □ other _____
3. Has your child ever been hospitalized for a severe reaction? □No □Yes If yes, when? _____
4. Describe your child's usual symptoms: _____
5. How have you treated allergic reactions? _____
6. List any medications your child takes daily for allergies:

Name of Medication	Dosage	Time

Does your child have any "as needed" medications or emergency medications? _____
7. Does your child take any other medications?

Name of Medication	Dosage	Time

8. List any side effects your child experiences from his/her medication? _____
9. Self-Care: Please circle responses

a.	Is your child able to monitor and prevent their own exposures?	No	Yes
b.	Does your child:		
	1. Know what foods to avoid	No	Yes
	2. Ask about food ingredients	No	Yes
	3. Read and understands food labels	No	Yes
	4. Tell an adult immediately after an exposure	No	Yes
	5. Wear a medical alert bracelet, necklace, watchband	No	Yes
	6. Firmly refuses a problem food	No	Yes
c.	Does your child know how to use emergency medication?	No	Yes
d.	Has your child ever administered their own emergency medication?	No	Yes

CONSENT

Please circle your response and sign:(I do /I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

DEPARTAMENTO DE SALUD DEL ESTADO DE LA FLORIDA EN EL CONDADO MIAMI-DADE

PROGRAMA DE SALUD ESCOLAR

HISTORIAL DE SALUD Y CONSENTIMIENO PARA ALERGIAS SEVERAS

Estudiante: _____ Fecha de Nacimiento: _____ Profesor/a: _____ Grado: _____
Escuela: _____Padre/ Guardian y Telefono _____
Doctor y Telefono: _____ Curso Escolar: 2020-2021
ALERGIAS: _____

Estimado Padre/ Guardian:
El expediente y la informacion escolar indican que su hijo/a tiene trastorno de indice de Alergia Severa. Con el objetivo de mantener la salud y seguridad del estudiante, la escuela require el historial medico. Por favor completar y retornar esta planilla al enfermero escolar, lo antes posible. Esta planilla formara parte del expediente de salud escolar confidencial. Nuestro objetivo primario es satisfacer las necesidades medicas durante el cuidado escolar

_____ _____ _____
Enfermero Escolar Numero de Telefono Fecha

1. Mencione a que es alergico su hijo/a? (Seleccione todas lo que apliquen)
Picadura de insecto- avejas, avispa, avispon, hormiga, mosquitos, aranas, otro: _____
Comidas- mani, nueces, leche, derivados lacteos, huevo, trigo, soya, chocolate, mango, mariscos, pescado, otro:_____
Goma de latex y/o algun otro medicamento (mencione) _____
Alergeno- polen, polvo, humo, caspa, vapores quimicos, otro: _____
2. Cuantas veces ha tenido su hijo/a una reaccion alergica? □1 □ 2-3 veces □ otro _____
3. Ha estado su hijo/a hospitalizado por alguna reaccion alergica severa? □No □Si, Cuando? _____
4. Describa los sintomas: _____
5. Como ha tratado reacciones alergicas? _____
6. Mencione los medicamentos que tome diariamente su hijo/a para las alergias:

Medicamento	Dosis	Horario

Tiene su hijo/a algun medicamento para emergencia? _____
7. Su hijo/a toma algun otro medicamento?

Medicamento	Dosis	Horario

8. Mencione algun efecto secundario que su hijo/a tenga por el medicamento? _____
9. Cuidado propio: Por favor, circule las respuestas

e.	Su hijo/a es capaz de reconocer y/o prevenir exposiciones?	No	Si
f.	Su hijo/a:		
	1. Sabe cual comida(s) evitar	No	Si
	2. Preguntar por los ingredientes de la comida	No	Si
	3. Leer y entender componentes alimentarios	No	Si
	4. Notificarle a un adulto inmediatamente despues de exponerse	No	Si
	5. Tiene un brazalete de alerta medico, collar, o pulzera	No	Si
	6. No aceptar comida que pueda causar alergia	No	Si
g.	Su hijo/a sabe como administrarse un medicamento para emergencia?	No	Si
h.	Alguna vez su hijo/a ha tenido que administrarse su propio medicamento para emergencia?	No	Si

CONSENTIMIENTO

Por favor **circule** su respuesta y firme: **(Yo consiento /Yo no consiento)** darle mi autorizacion al enfermero escolar para compartir informacion relevante del estado medico de mi hijo/a con el personal concerniente, si el enfermero escolar determina que esta informacion es necesaria para asegurar la seguridad y salud de mi hijo/a

Firma del Padre/ Guardian: _____ Fecha: _____

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE
SCHOOL HEALTH PROGRAM
ROLES AND RESPONSIBILITIES: SEVERE ALLERGIES

Student: _____ DOB: _____ Teacher: _____ Grade: _____

Parent/Guardian & Phone(s): _____ School Year: 20**20**-20**21**

SEVERE ALLERGY ACTION PLAN: Follow the attached physician action plan.

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Epinephrine auto injector Kept: Staff authorized to administer epinephrine auto injector (review plan, recognize symptoms and respond):	1. Provide medication for school site/replace any expired medication. Exp. Date: _____	1. Report any signs/symptoms
2. Staff to administer medications per MDCPS training:	2.Keep school staff informed of any changes in student condition or medications	2. Do not trade food with others
3. Staff to contact 911/parent/guardian:	3. Available to accompany student on field trip and carry the epinephrine auto injector (complete school volunteer form). Alternate for parent/guardian (complete volunteer form):	3. **If applicable**, carry epinephrine auto injector as directed by physician.
4. Staff to direct EMS to the emergency	4. (Severe Food Allergies) Provide all meals/snacks for student	
5. CPR certified staff:	5. If applicable, check student is carrying epinephrine auto injector as directed by physician	
6. Prevention at school site: School grounds: Control of insects Contact MDCPS Safety, Environment, Hazards Management Cafeteria: _____ free table or clean table with single use paper towel with MDCPS approved cleanser. Cafeteria Manager: Teacher/paraprofessional to carry school two- way radio		
7. Substitute teacher instructions:		

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or School Administration Designee Date

_____ _____
School Nurse Date