Farmington Public Schools
AUTHORIZATION FOR MEDICATION FORM

Dear Parent and physician:

PLEASE READ THE ATTACHED MEDICATION ADMINISTRATION GUIDELINES ON THE BACK OF THIS FORM.

PHYSICIAN PLEASE COMPLETE THE FOLLOWING:

Student Name_____

Name of Medication_____ Dosage_____

Route Given_____ Time_____

Start Date_____ End Date_____

Student's diagnosis and reason for medication_____

_____

Adverse reactions or side effects_____

_____

Additional Comments_____

Students may self carry/administer (grades 6-12) only if authorized by the physician and parent/guardian.

-This student is both capable and responsible for self-administering this medication according to school policy

___No ___Yes-Supervised ___Yes-Unsupervised Physician Initials_____

-Student is authorized to self carry this medication:

___No ___Yes Parent/Guardian Initials_____

___Please indicate if you have provided additional information as an attachment.

I certify this student requires such medication be given during school hours and that no alternative schedule is medically advisable.

Physician Signature_____ Date_____

Print Name_____ Phone_____

Address_____

City/State_____ Zip Code_____

Parent/Guardian Signature_____ Date_____

**Return fax to: 248-489-3839 (Farmington Public Schools)

Farmington Public Schools
Medical Record Update

This form is required in order to certify the student for appropriate Special Education Services. It must me completed and signed by both the parent/guardian and physician.

Student Name:_____ **DOB**:_____

- Date of Last Physical Exam:_____
- Student Medical Diagnosis:_____

_____

_____

- Is this a lifelong diagnosis or will it be resolved with treatment/time:_____
- Medication (include prescription, over the counter, and herbal):_____

_____

_____

- Allergies (include all medication, food, seasonal, etc):_____

_____

- Up to Date Immunizations: Yes____ No____ (Please attach current immunization record)

- List of Medical Procedures (MRI, CT scan, swallow study, etc):_____

_____

_____

- Surgical History:_____

_____

_____

Please continue to other side to complete and sign this form

- Orthopedic Impairment: Yes____ No____

If yes, describe:_____

_____

- Neurological Impairment: Yes____ No_____

If yes, describe:_____

_____

- Hearing Impairment: Yes____ No____ Hear Aids: Yes____ No____

If yes, describe:_____

- Vision Impairment: Yes____ No____ Glasses: Yes____ No____

If yes, describe:_____

- Are there any other medical factors that the school should be aware of that might affect the student's

educational performance:_____

_____

_____

I certify that the information on the form is current and correct.

Physician Signature:_____Date:_____

Print Name:_____Phone:_____

Address:_____

City/State:_____Zip Code:_____

Parent/Guardian Signature:_____Date:_____

Please return this form to Farmington Public Schools, 33000 Freedom Road, Farmington, MI 48336
Phone: 248-489-3833 Fax: 248-489-3839

Farmington Public Schools

AUTHORIZATION FOR MEDICAL PROCEDURE

Parent/Physician:
Please read the **procedure guidelines on the back of this form** then complete, sign and return to school if you wish to authorize district staff to perform a specific medical procedure during school hours.

PHYSICIAN PLEASE COMPLETE:

Student's Name_____ School_____

Medical Diagnosis and reason for procedure_____

_____

Type of Procedure:

- Oxygen Administration

Frequency_____ Rate of Delivery_____

- Oral Suction_____
- Tracheal Suction_____
- Tube Feeding: G-tube _____ J-Tube _____ Time (s) _____

Formula_____ Amount_____

Bolus_____

_____

Gravity Drip_____ Bolus_____

- Urinary Catheterization: Catheter Size_____ Type_____

Frequency/Time_____

- Other Procedure_____

_____

Physicians Signature_____ **Date**_____

Print Name_____ **Phone**_____
Address_____
City/State_____ **Zip**_____

Parent/Guardian Signature_____ **Date**_____

Return fax to: 248-489-3839 (Farmington Public Schools)

School Year_____

ALLERGY ACTION PLAN (AAP)

Farmington Public Schools

Place Student Picture Here

(Face Only)

Student Name_____BD_____

School_____Grade_____Teacher_____

The back of this form must be signed and dated by both the parent and treating physician or licensed prescriber.

Parent Contact Information

Parent/Guardian_____Relationship_____

Home_____Cell_____Work_____ _____

Parent/Guardian_____Relationship_____

Home_____Cell_____Work_____ _____

Emergency Contact (If parent/guardian cannot be reached)

Name_____Relationship_____Phone_____

Allergic History

List all Foods student is allergic to: (If nuts, specify: Peanuts Tree Nuts Both)

_____ _____

List all Non-Food allergies (including: Insect stings, Latex, Medication, Exercise, etc.)

_____ _____

Does your child have Asthma? Yes___(higher risk of severe allergic reaction) No___

If yes, please complete a separate **Asthma Action Plan** and if needed an **Authorization for Medication Form**

Does your child have Eczema? Yes___ No___

History of Anaphylactic Reaction? Yes___ No___ Was an Epinephrine injection given? Yes___ No___

Comments_____ _____

MEDICATION/DOSES PRESCRIBED (Parent/Guradian is responsible for suppling all medication)

Antihistamine (Brand name and dose)_____

Location_____

Epinephrine (0.15mg Junior) (0.3mg Adult) (Brand:_____

Location_____

Please Note: Only Secondary (Grade 7-12) students may Self-Carry/Self-Administer Medication

This student is both capable and responsible to self-carry Epinephrine.

No___ Yes___ Physicians Initials_____

Note: If a student is to self-carry his/her epinephrine, help may still be needed to give the medication.

Student is authorized to carry this medication. Yes___ No___ Parent/Guardian Initials_____

If Student is to self-carry epinephrine, school will be supplied with a back up auto-injector. Yes___ No___

Extremely reactie to the following:_____

THEREFORE:

____If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

____If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

If ANY SEVERE SYPMTOMS after suspected or known ingestion (or contact, if allergen other than food)

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips)

SKIN: Many hives over body

Or combination of symtoms from different body areas:

SKIN: Hives, itchy rashes, swelling (eyes, lips, etc.)

GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (See "monitoring" box below)
4. Give additional medication**
   If ordered such as: Antihistamine or Inhaler

*Antihistamines & Inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

IF MILD SYMPTOMS ONLY:

Mouth: Itchy mouth

Skin: A few hives around mouth/face, mild itching

Gut: Mild nausea/discomfort

1. **Give Antihistamine**
2. Stay with student; Call parent/guardian
3. If symptoms progress:
   USE EPINEPHRINE (see above)
4. Begin monitoring (see below)

MONITORING: Stay with student; call 911 first then call parent/guardian

Note dose/time epinephrine administered and give information to EMS

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur

Consider keeping student lying on back with legs raised (if vomiting roll student to his/her side)

Treat student even if parent/guardian cannot be reached.

I am in agreement and authorize the medication/plan as stated in both pages 1 and 2 of this *Allergy Action Plan*

Physicians Signature:_____ **Date:**_____

Print Physicians Name:_____ Phone:_____

Address:_____

City/State:_____ Zip Code:_____

Parent/Guardian Signature:_____ **Date:**_____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____ Date of Birth _____

Parent/Guardian _____ Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

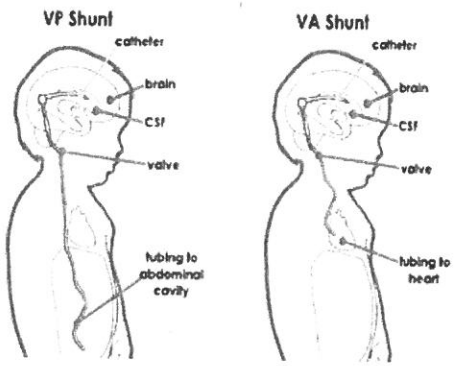
DPC772

Ventricular Shunt Action Plan

Student Name:_____DOB:_____

Does the student have a shunt? Yes___ No___ If yes what type: VP__ VA__

A ventricular shunt is a drainage tube inserted into the ventricular system of the brain. It allows excess cerebral spinal fluid to drain into a deposit site within the body. The deposit site or the opposite end of the drainage tube is usually within the peritoneal (abdominal) cavity (VP) but can also drain into the right atrium of the heart (VA) or the pleural space surrounding the lungs



In the event of a shunt malfunction, the excess cerebrospinal fluid is unable to drain and intracranial pressure builds. This can become life threatening so recognition and response to signs and symptoms of increasing intracranial pressure is vital.

Potential Warning Signs: Notify School Nurse/Parent

- Behavior-persistent irritability, personality changes, decline in school performance, lethargy/fatigue, uncontrollable/unusual crying or whining
- Digestive-complaints of stomach pain, nausea, loss of appetite, forceful or projectile vomiting not related to feeding
- Neurological-dizziness, complaints of headache, blurred vision (abnormal eye movements), seizures (or increased seizure activity)
- Shunt Tract-bulging, redness or fullness along the tract, complaints of stiff neck (unable or unwilling to bend head forward)

❖ **Call 911 immediately: If above warning signs are progressing quickly and/or student experiences loss of consciousness.**

If student experiences even a minor head or neck injury while at school staff should notify school nurse/parent. Carefully monitor for the above signs throughout the remainder or the school day and act accordingly.

Signing this form means you have read and agree to the information stated above. Please add any further information that you would like to add regarding your student:

_____

_____

Parent/Guardian Signature:_____**Date:**_____

Phone: (h)_____**(c)**_____