BCSD Health Services Anaphylaxis Authorization Form 2024-2025

BCSD 8/2022

THIS FORM MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY - PLEASE PRINT

Student's Legal Name:	**Date of Birth:**
List Allergies :	

Prescribed epinephrine type: Auto-Injector	**Prescribed Dose:** ☐ **0.15 mg** (Wt <66 lbs green) ☐ **0.3 mg** (Wt >)	**Prescribed Route:** Intramuscular
Prescribed antihistamine:	**Prescribed Dose:**	**Prescribed Route:**

Specific instructions for medication administration (example: give diphenhydramine prior to epinephrine)**:**

Symptoms may start as: (check all that apply)

- ☐ Itching and swelling of the lips, tongue or mouth
- ☐ Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Hives, itchy rash and/or swelling around the face or extremities
- ☐ Shortness of breath, repetitive coughing and/or wheezing
- ☐ Thready pulse or passing out
- ☐ Other _____

Bus Travel This student must have his/her **epinephrine** available on the bus to and from school: ☐ Yes ☐ No

Student has permission to self-carry / self-administer this medication: ☐ **No** ☐ **Yes – if yes, read the following carefully:**

If yes box is checked, I agree that this student must be allowed to have the above named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Health Care Provider: _____ Phone: _____

Health Care Provider Signature: _____ **Date**: _____

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following*:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BCSD staff to administer this medication to my child according to district requirements.
- BCS Transportation department staff are required to complete online training for health emergencies annually. Additional training by a licensed BCS nurse will be provided as warranted.
- I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).
- ***My student has orders from our health care provider to Self-Carry/Self-Administer this medication:***
  ☐ ***No*** ☐ ***Yes *If yes, read the following carefully:***

*Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. **My child has been trained by our physician and has demonstrated competency in this procedure.** My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Beaufort County cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions (except emergency medications). I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Parent/Legal Guardian Printed Name: _____ Daytime Phone Number: _____

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

This form is only valid if signed on or after July 1st for the upcoming school year.

2024-2025

SS-46(E)(1)

BCSD Prescription Medication

Permission for School Administration

IHP ☐
EAP ☐

Must be completed by the child's healthcare provider and parent/legal guardian

Please note the following:

1. Medication should be administered by a parent/legal guardian before or after school hours, when possible.
2. Medication must be brought to the school nurse by a responsible adult**. (Do not send medication in with a child.)**
3. All prescribed medications must be provided to the school in the original labeled container issued by the pharmacist and accompanied by this permission form. **(the label and the healthcare provider's order on this form must match)**
4. Any prescribed controlled substance must be brought to the school nurse by the parent/legal guardian when the prescription is filled each month and must be provided to the school nurse in the most recent pharmacy labeled container.
5. "Sample" medication must be provided in a container appropriately labeled, which identifies the medication and must be accompanied by a note signed and dated by the healthcare provider that includes the student's name and directions for proper administration, along with this permission form.
6. Herbal medications/substances are not FDA approved and will not be administered by the school nurse.
7. First doses of a medication that a child has never received will not be given at school.
8. BCSD may reject requests for certain medications to be given at school.
9. This form is still valid and in effect if the child transfers to another school within BCSD for the current school year.
10. MUST complete a **separate form for each medication** that is to be given at school.

Child's Full Name: _____ **Grade Level:** _____

Date of Birth: _____ **Gender: Male ☐ or Female ☐**

Section below must be completed and signed by the child's HEALTHCARE PROVIDER:

Name of **Prescription Medication** to be given at school**:**		**Reason(s)** for this Medication to be given at school**:**
Prescribed **Dose/Strength:** (i.e. 50 mg, mcg, grams)	**Amount** to be given at School**:** (i.e., 1 tab, 5 ml, 0.5 tab, 2 puffs)	**Frequency or Time** to be given at school**:** (For time, please specify preferred time. "Lunch" times vary from 10:30a-1p)
Prescribed **Route**:	**Controlled Substance:** ☐ No ☐ Yes	**Number of days medication** is to be given at school**:** ☐ until the end of the current school year ☐ _____day(s)
List **possible side effects** from this medication**:**		**Special Storage Required:** ☐ No ☐ Yes _____

Prescribing Health Care Provider's Name & Office: ***(please print or stamp)*** **Office Phone:**_____

Fax: _____

Signature of Healthcare Provider: _____ ***Date:*** _____

***Please note that this form is only valid if signed and dated on or after July 1 for the upcoming school year**

Section below must be completed and signed by the PARENT / LEGAL GUARDIAN:

Does this child have **any known allergies?** ☐ No ☐ Yes

(If yes, list all known allergies and type of reaction(s): _____

Does this child **take any additional medications at home or at school?** ☐ No ☐ Yes

(If yes, list the medications taken at home): _____

I understand and agree with all the following:

- I give permission for my child to be given the above medication as prescribed while at school per BCSD policies.
- I give permission for information about this medication and/or my child's health to be exchanged between the BCSD school nurse or designated BCSD employee and/or the Health Care Provider, the pharmacist who filled this prescription, and/or their designee.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree to allow student's medication to travel with teacher/staff on field trips if medication time occurs during field trip.
- I agree to follow the BCSD policies concerning medications.
- I agree that it is my responsibility to provide the school with the medication for my child and any supplies needed.
- I agree that it is my responsibility to notify the school if my child's health and/or medication(s) change in any way.

Parent/Guardian's Signature **Parent/Guardian's Name (Print)** **Date** **Phone Number**

Updated 3/2023

BCSD Health Services Asthma Authorization Form 2024-2025

BCSD 5/2023

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY - PLEASE PRINT

Student Name:	**Birthdate:**
List **Known Allergies** and/or **Asthma Triggers** include:	
Usual asthma symptoms include but not limited to:	
Prescribed Rescue Medication:	**Spacer Recommended**: No ☐ Yes ☐

Prescribed Frequency and Dose :

☐ As Needed for Rescue Treatment Give _____ Puffs

☐ Before PE/Recess/Strenuous Activity Dose; Give _____ Puffs (Scheduled Doses should be 4 hours apart)

☐ Sick Plan: Scheduled Rescue Treatment Give _____ Puffs every _____ hours and before PE/Recess/Strenuous Activity

It is the responsibility of the parent to notify the school nurse if the student is on a sick plan & for how long.

For Rescue Treatment:

1. Observe student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved.
2. If student is still experiencing breathing difficulties after 20 minutes:
   IT IS ☐ **or** IS NOT ☐ okay to repeat rescue treatment dose for up to a total of _____times to relieve breathing difficulties.

Daily Asthma Control Medication(s) prescribed for **at home** use**:**

Student has permission to self-carry / self-administer this medication: ☐ **No** ☐ **Yes – if yes, read the following carefully:**

If yes box is checked, I agree that this student must be allowed to have the above named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Health Care Provider: _____ Phone: _____

Health Care Provider Signature:_____ **Date**: _____

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following*:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BCSD staff to administer this medication to my child according to district requirements
- I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).

. ***My student has orders from our health care provider to Self-Carry/Self-Administer this medication:***

☐ ***No*** ☐ ***Yes *If yes, read the following carefully:***

*Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. **My child has been trained by our physician and has demonstrated competency in this procedure.** My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Beaufort County cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Parent/Legal Guardian Printed Name: _____Daytime Phone Number: _____

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

This form is only valid if signed on or after July 1st for the upcoming school year.