WEST ORANGE HIGH SCHOOL

HEALTH OFFICE

51 CONFORTI AVENUE
WEST ORANGE, NJ · 07052-2829
Tele: 973-669-5301 X31521, X31522, X31524
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DENISE MAKRI-WERZEN RN/MT(ASCP)CSN/HT, SCHOOL NURSE SONIA KELLEHER, BSN, CSN, RN, SCHOOL NURSE

School year 2011-2012

Dear Parent/Guardian of _____

Our health records indicate your child has an illness/condition that requires administration of medications during the school day. Therefore, the school policy dictates that you need to provide us with new and updated medical forms, filled out by your physician and guardians, at the beginning of each school year. **Please take note that all meds, including over the counter meds, require these forms be filled out each school year.**

MEDICAL ILLNESS/CONDITION: Please have your physician complete and sign the attached forms. Be sure to complete Step 2: Emergency Calls. We must have accurate phone numbers of those persons to be contacted in an emergency. It is imperative that these forms and meds be returned to the Nurses' Office as soon as possible.

DAILY OR AS NEEDED MEDICATION ADMINISTRATION: **Please bring the medication in its original container,** labeled with your child's name, physician name and phone number. Please **bring all completed medical forms and the medications to the Nurses' Office as soon as possible.**

SELF-ADMINISTRATION MEDICATON: If your child is allowed to self-administer emergency medication (i.e. Epipens, inhalers, etc) the medication must labeled with your child's name, name of medication, strength, dose, frequency, physician name with phone number and emergency contact phone numbers. If you would like to keep back up medications in our office, please bring properly labeled med containers and **completed** forms, **including *Parental Permission and Waiver* form and the *Physician Authorization for Self-Administration of Medication* form.**

The school nurses **cannot** administer any medication, or allow a student to carry medication without written authorization from you, the parent/guardian **and** the student's physician.

If at any time the information you have provided changes, including medication changes or discontinuation, you need to contact us immediately, and provide an MD note for those changes.

By the end of the school year, any medications you may have in our health office needs to be picked up by you. If the medications are not taken home, they will be discarded.

Thanking you for your cooperation and attention to this matter. Please feel free to contact us with any further questions.

Sincerely,

DENISE MAKRI-WERZEN AND SONIA KELLEHER- W.O.H.S. NURSES

Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ 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†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

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 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

PHYSICIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

The following sections are to be completed by the student's physician

Section I

Name of Student _____

Birth Date _____ **School** _____ **Grade** ____

I certify that the above-named student has a potentially life-threatening illness and is capable of, and has been instructed in, the proper method of self-administration of the medication(s) listed below:

Physician's Signature _____ Date _____

Section II

A. Diagnosis for which medication (s) is/are taken _____
_____

B.

	Medication	Dosage	Frequency	Major Side Effects
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

C. How long has student been taking above medications?

1. _____

2. _____

D. Other information or comments about student or medication:

_____

_____

Physician's Signature _____ Date _____

Physician's Name _____ Telephone _____

1/05

REQUEST FOR INJECTION BY EPINEPHRINE PEN

To: The West Orange Public Schools

From: _____
Parent

Re: _____
Student's Name D.O.B. School

My child is severely allergic to the following substances:

_____

_____

_____

He/she needs to receive immediate medication with an "epinephrine pen" if he/she is exposed to any of the above substances or has any of the common signs or symptoms of anaphylaxis which include hives or rash, swelling of face and/or extremities, tingling of lips and mouth, flushing of face or body, coughing, wheezing, dyspnea (shortness of breath), nausea, vomiting, abdominal cramps, diarrhea, tachycardia (increased heart rate), postural hypotension (low blood pressure), and syncope (fainting). This also applies to other signs on individualized care plan. **My child will be able to:**

1. **self-administer _____ 2. will not be able to self-administer _____ the epinephrine pen injection.**

Enclosed is my physician's written orders to the Board of Education that my child cannot self-administer with an epinephrine pen and needs administration by a designated staff member. My consent to have a staff member administer the medication through an epinephrine pen is only good for this school year. I understand that I may renew my consent in future school years.

I understand that because of his/her severe allergies, someone needs to be able to administer the epinephrine to my child in the absence of the school nurse. I agree to the designated staff member(s) providing the injection from a prefilled single dose "pen" following training by the nurse.

The designee will be covered under the West Orange Public School's insurance while providing this medication to the student. I also understand that if the procedures in the statute are followed as set forth, The Board of Education, and its employees or agents, shall have no liability for any injury arising from administration of medication with an epinephrine pen and I will hold harmless and indemnify the Board of Education and the staff member against any claims arising out of the administration of the epinephrine pen to my child.

Parent(s) Signatures _____ Date _____

Principal's Signature _____ Date _____ Nurse's Signature _____

Designee's Signature _____ Date _____

6/05 IDG

THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

PARENTAL PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Student _____ DOB_____ Age _____ Grade _____

I, the parent of _____ give permission for my child to self-
(student's name)
medicate for asthma or other potentially life-threatening illness for the school year.

Signed: _____ Date: _____
Parent's/Guardian's Signature

MEDICATION WAIVER

Student _____ DOB_____ Age _____ Grade _____

This acknowledges that the district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication.

Signed: _____ Date: _____
Parent's/Guardian's Signature

1/05

THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

To: Physicians & Parents

We are writing to ask for your cooperation as we attempt to best serve the children in our schools regarding the administration of medication during school hours.

The West Orange Public Schools' policy regarding the administration of medication during the school hours is as follows:

1) Parents & treating physicians are responsible for the diagnosis and treatment of a student's illness. The administration of prescribed medication to students during school hours will be permitted when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine was not available during school hours.

2) Pupils requiring medication at school must have a written statement from the family's physician that identifies the type, dosage, time schedule, purpose of the medication and possible side effects.

3) A written statement from the parent or guardian of the pupil giving permission for the school nurse to give the medication prescribed by the family physician is required.

4) Any medication to be administered during school hours must be kept in the health office.

Sincerely,

School Nurse

PARENT'S REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

Student _____ DOB _____ Grade _____ School _____

I, the parent of _____. request the school nurse administer the medication
(student's name)
prescribed by _____ _____ for the period from
(Physician's Name)
_____ to _____.
(Date) (Date)

The medication is to be furnished by me and is to be pharmacy-labeled with the name of the medicine, the amount to be given, time of day to be taken, and the expected duration of treatment. The physician's name must also be on the label. The school nurse has my permission to contact Dr. _____ at _____ to the administration and effect of the medication.
(Telephone #)

_____ _____
(Parent's signature) (Date)

PHYSICIAN'S REQUEST FOR GIVING MEDICATION AT SCHOOL

Date _____

Student's Name _____ DOB _____

To: _____, School Nurse at _____ School
Rx _____
Dosage _____
Time/special circumstances of administration _____
Period of Time _____
Purpose of Medication _____
Possible side effects _____

Physician's Name _____ Date _____
Physician Signature _____

6/05 IDG