Holy Family Regional School 2300 Beasley Avenue, Huntsville, Al 35816
Phone: 256-539-5221 Fax: 256-533-0747

Instructions for the School Medication Prescriber/Parent Authorization Form (PPA) & Management Plan, (IHP) Individualized Healthcare Plan, (EAP) Emergency Action Plan, and (CAP) Classroom Action Plan for ALLERGY

1. **(IHP) Individualized Healthcare Plan/(EAP) Emergency Action Plan/(CAP) Classroom Action Plan**
   - Section I – Parent/Guardian must complete.
   - Section II – Physician, Physician's Assistant, or Nurse Practitioner must complete.
   - Signatures - Parent/Guardian, Physician, Physician's Assistant, and/or Nurse Practitioner must sign and date.

Alabama Board of Nursing requires the following to be completed on all (PPAs) for each Med/Dose

2. **School Medication Prescriber/Parent Authorization Form (PPA)**
   - **Prescriber Authorization Section: (Prescription & Over-the-Counter Medications)**
     - Every blank must be completed to include: med, dosage, time, route, start and stop dates, reason, special instructions, sign and date,
     - Med(s) will not be accepted or administrated with an incomplete and/or incorrect PPA,
     - Complete one PPA for each med & each dose,
     - Start Date and Stop Date - Please list specific dates,
     - Use as Directed instructions will not be accepted - must be specific,
     - Frequency/Time(s) to be given – "as needed", please include time parameters (example: every 4 hours as needed), and
     - Self-Administer/Self-Carry - Only med(s) to prevent &/or treat medical emergencies are acceptable.
   - **Parent/Guardian Section**
     - **Student Information Section**- Parent/Guardian must complete every question including: allergies, weight and birth date,
     - **Parent Authorization Section**- Parent/Guardian must sign and date, and
     - **Self-Administration Authorization Section**- Parent/Guardian must sign and date to allow student to self-medicate and/or self-carry approved med at school.

Parent/Guardian must bring in PPA(s), medication(s), and management plan(s) directly to the school nurse or designated medication assistant. Students, unless prescribed to 'Self-Administer/Self-Carry', may not bring in their own medication(s). All medications (to include over-the-counter & prescription) must be counted and logged-in each time.

Expired Medication(s): Please be aware of medication expiration dates. You will be notified when your child's med expires.

End of School Year: All medication(s) must be signed out at the end of the school year. Medication(s) left in the clinic after that time will be discarded according to federal and state guidelines.

Sincerely,

School Nurse

If you have received this packet in error, or if your student's medical condition does not require emergency planning, please sign below and return this form to your child's teacher or school nurse.

❑ Received in error ❑ Student's medical condition does not require medication and/or emergency planning

Student Name: _____

Comments: _____

Parent/Guardian Signature: _____ Date: _____

HCS School: _____ Start Date: _____ School Hours: _____

Stop Date: _____ Extracurricular Hours: _____

MANAGEMENT PLAN for SEVERE ALLERGY WITH MEDICATION: _____

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Action Plan (CAP) / Bus Plan

SECTION I –Parent (Please Print) **Student has Asthma?** **YES** ☐ **NO** ☐

Student Name: _____ DOB: _____ Teacher/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Parent Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II –Physician (Please Print)

If student "self-carries" medication, a "back up" medication may be kept in clinic? **YES** ☐ **NO** ☐

The severity of symptoms can change quickly and potentially progress to a life threatening situation.

IF YOU SEE THIS...	DO THIS...
Contact with or ingestion of allergen with no symptoms **OR** Symptoms of mild or early allergic reaction: • Itching of skin, mouth or ear canal • Rash, Hives • ***No Respiratory Distress*** • _____ • _____	1. Administer medication? ☐ Yes ☐ No *Medication: _____ *Medication dosage: _____ 2. Remain with Student. Call school nurse at extension: ____ 3. Call parent/guardian or emergency contact 4. Observe student for ____minutes before return to class 5. Recheck student in _____ minutes
Symptoms of **Severe Allergic Reaction**: (Anaphylactic Shock) • Mouth Tingling, Swelling of Face/Lips/Tongue/Throat • Nausea, Vomiting, Diarrhea, Abdominal Cramps • Cough, Wheeze, Stridor, **Respiratory Distress** • Chest Pain, Turning Blue, Very Pale • Weak Pulse, Low BP • **Student states, can't breathe or swallow** • Unconscious	*Administer Epinephrine? ☐Yes ☐ No ☐ Epipen: ☐0.3 mg ☐0.15 mg ☐ Twinject: ☐0.3 mg ☐0.15 mg ☐ Auvi-Q: ☐0.3 mg ☐ 0.15 mg **Follow instructions for administration as illustrated on box.** 1. **Call 9-1-1** 2. Call parent/guardian or emergency contact 3. Remain with student until 911 personnel arrive 4. Give used auto injector, to 911 personnel, if administered **May repeat above Epinephrine dose if no improvement in signs/symptoms after 15 minutes?** ☐Yes ☐ No

* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER

FIELD TRIPS: Emergency Medication *should NOT be left* in a backpack on the bus or with a teacher who is not with the student.

BUS PLAN: Recognize Symptoms, Pull Over, Call 911, & Parent/Guardian.
Only self-carry/self-administer medications will be available.

EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

_____ Physician Signature Date _____ Parent Signature Date _____ Student Signature Date _____ Nurse Signature Date

FOR SCHOOL NURSE USE ONLY

Medication	Self-Carry?	Self-Administer?	Expiration	Location of Medication

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

❑ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ❑ No ❑

Is self- medication permitted and recommended? Yes ❑ No ❑

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ❑ No ❑

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( ) _____-_____ **Fax:** _____-_____

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

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone:** ( ) _____-_____