Holy Family Regional School 2300 Beasley Avenue, Huntsville, Al 35816
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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: _____

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HCS School: _____ **School District:** _____ **School Hours:** _____
Onsite Nurse Name _____ **Start Date:** _____ **Extracurricular Hours:** _____
Onsite Nurse Phone# _____ **Stop Date:** _____ **Extracurricular Activity:** _____

MANAGEMENT PLAN for SEVERE ALLERGY WITH MEDICATION (List Allergen): _____

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

SECTION I –PARENT (Please, Print) Student has Asthma with medication? ❑ YES ❑ NO **IEP?** ❑ YES ❑ NO **504 PLAN?** ❑ YES ❑ NO

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

Student Home Address: _____

Known Allergies/Triggers: _____ WT _____ HT _____

Medications Taken at Home: _____

Potential Side-Effects of Home Meds: _____

Bus Transportation ❑ YES ❑ NO Bus # a.m. _____ Bus # p.m. _____ Fieldtrip/Extracurricular Bus Transportation ❑ YES ❑ NO

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

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

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

Physician: _____ Phone#: _____ Fax#: _____

Physician Address: _____ Preferred Hospital: _____

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

SECTION II –PHYSICIAN (Please, Print) **EMERGENCY ACTION PLAN (EAP)**

A signed medication PRESCRIBER/PARENT AUTHORIZATION (PPA) FORM is required for each medication

Is a medication PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? ❑ YES ❑ NO

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*** • Other: _____	1. Administer medication? ❑ Yes ❑ No *Medication: _____ dose per PPA 2. Remain with Student. Call School Nurse at extension: _____ 3. Call Parent/Guardian and/or Emergency Contact 4. Observe student for ____ minutes before return to class 5. Recheck student in ____ minutes
Symptoms of **Severe Allergic Reaction**: (Anaphylactic Shock) • Tingling or Swelling of Mouth/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, throat is closing** • Unconscious • Other: _____	*Administer Epinephrine? ❑Yes ❑ No ❑ Epipen: ❑ 0.3 mg ❑ 0.15 mg ❑ Other Epinephrine Rx: ❑ 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 5. Be prepared to administer 2nd dose of Epinephrine, if ordered by prescriber and available. 6. Observe student for potential side effects: rapid heart rate, and drowsiness. Notify School Nurse, if not present

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital, 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 & 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

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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:** ( ) _____-_____