AUTHORIZATION OF ADMINISTRATION OF ORAL/TOPICAL MEDICATION

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student			
Birthdate		**Grade**	
Address			
Postal Code		**Telephone**	
Parent's/Guardian's Name			
Business Address			
Postal Code		**Telephone**	

PARENT/GUARDIAN APPROVAL

I hereby request and give permission to {Name of School} _____ to administer Oral/topical medication to my child according to School Board procedures and the instructions of the Physician. I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Parent/Guardian: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Condition of Patient for which Oral/Topical Medication is Necessary	
Name of Medication	
Dosage or Amount to be Given Each Time	As Indicated on Prescription Label
What Time(s) Dosage to be Given	As Indicated on Prescription Label
Method of Administration (with Food?)	
Possible Side Effects	
Storage and Safekeeping Requirements for Medication	
Prescribing Physician's Name {Please Print}	
Office Address and Telephone Number	

Signature of Physician: _____ Date: _____

EMERGENCY ACTION PLAN FOR STUDENTS WITH ANAPHYLAXIS

For Use Where Applicable (e.g. in: Classroom, Lunchroom, Staff Room, Office, Out of School Programs)

Name: _____

Allergen(s): _____

ALLERGY DESCRIPTION

This child has a DANGEROUS, life threatening allergy to the following:

_____

_____

_____

Place Student's Photo Here

(to be provided by parent)

RESTRICTIONS

List restrictions for this student, if any: _____

_____

_____

POSSIBLE SYMPTOMS (order may vary)

BODY SYSTEM	SYMPTOMS
SKIN	hives (red itchy welts or swelling on skin)
EYES	swollen, itchy, running, or bloodshot, or with mucous
NOSE	running, itchy, stuffy, sneezing
THROAT	sore, swollen
STOMACH/DIGESTIVE SYSTEM	vomiting, cramps, bloating, nausea, diarrhea
URINARY SYSTEM	Incontinence
RESPIRATORY SYSTEM	difficulty breathing, severe asthmatic reaction
CIRCULATORY SYSTEM	drop in blood pressure, unconsciousness
OTHER	disorientation, sense of foreboding, fear or apprehension, sense of doom

EMERGENCY ACTION PLAN

School Administrators must fill out an O.S.B.I.E. incident form any time a student is taken by ambulance to a hospital as the result of an anaphylactic reaction.

NOTE: **Epinephrine auto-injector** (e.g., EpiPen®) is/are kept: _____

Expiry Date:_____

KNOW WHAT TO DO: The first signs of reaction can be mild but symptoms can get much worse quickly.

- **Use epinephrine auto-injector (e.g., Epipen®) immediately.**
- **Call 911 and advise the dispatcher that a child is having an anaphylactic reaction.**
- **If ambulance has not arrived in 10-15 minutes and breathing difficulties are present, give a second epinephrine auto-injector (e.g., Epipen®), if available.**
- **Even if symptoms subside entirely, this child must be taken by ambulance to the hospital.**

Name of Doctor: _____ Date: _____

Signature of Doctor: _____

Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____

Signature of School Administrator: _____ Date: _____

Permission to Post (where applicable) ○Yes ○No

District School Board of Niagara

ADMINISTRATIVE PROCEDURE

EMERGENCY ACTION PLAN FOR STUDENTS WITH MEDICAL NEEDS

For Use Where Applicable (e.g. Classroom, Lunchroom, Out of School Programs)

Date: _____

Student Name: _____

Teacher Name: _____ Class: _____ Room #: _____

Parent/Guardian Name: _____

Telephone #: _____ Emergency #: _____

Alternate Contact: _____

Name of Doctor: _____

Place student's photo here

(to be provided by parent/guardian)

MEDICAL DIAGNOSIS

This student has: ❍ Asthma ❍ Epilepsy ❍ Diabetes

❍ Other: _____

_____

RESTRICTIONS

(List restrictions for this student, if any)

POSSIBLE SYMPTOMS

MEDICATIONS

(Note: If expiry date has passed, medication will not be used. An ambulance will be called).

Note: Medication is kept (where)

continued on next page →

EMERGENCY ACTION PLAN	Note: Principals must fill out an O.S.B.I.E. Incident Form any time a student receives medical care.

AUTHORIZATION

Name of Doctor: _____ Signature of Doctor: _____

Date: _____

Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____

Date: _____

Name of Principal: _____ Signature of Principal: _____

Date: _____

Permission to Post (where applicable) ❍ Yes ❍ No

COPY TO OSR

District School Board of Niagara

ADMINISTRATIVE PROCEDURE

Place Student Photo Here

STUDENT ASTHMA MANAGEMENT PLAN

(To be completed by parent/guardian)

STUDENT _____ AGE _____

TEACHER _____ GRADE _____

EMERGENCY CONTACT (List in priority of contact)

	Name	Relationship	Daytime Phone	Alternate Phone
1.				
2.				
3.				

KNOWN ASTHMA TRIGGERS

☐ Colds/flu ☐ Physical activity ☐ Hot or cold weather ☐ Strong smells ☐ Pets ☐ Pollen ☐ Allergies (specify): _____

☐ Anaphylaxis (specify allergy): _____ ☐ Other (specify) _____

RELIEVER INHALER (FAST-ACTING, USUALLY BLUE)

Use reliever inhaler _____ (name of medicine) in the dose of _____ (number of puffs) Spacer provided? ☐ Yes ☐ No

Reliever inhaler is used to:

- ☐ Relieve symptoms being experienced (see "MANAGING ASTHMA ATTACKS" below)
- ☐ Other (please explain)

☐ Student requires assistance to access and use reliever inhaler. Make sure it is readily accessible by teacher/supervisor.

☐ Student will carry their inhaler at all times including outdoor activities and field trips.

We agree _____ (Insert student name) is responsible for carrying his/her inhaler at all times (including recess, gym, outdoor and off-site activities).

Parent/guardian signature: Student signature: Date:

MANAGING ASTHMA ATTACKS

MILD ASTHMA ATTACK

If **ANY** of the following occur:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)

Student may also be restless, irritable and/or very tired.

Step 1: **Immediately** use fast-acting reliever inhaler (usually a blue inhaler).

Step 2: Check symptoms. Only return to normal activity when all symptoms are gone.

If symptoms get worse or do not improve within 10 minutes, this is an **emergency** – follow steps below.

ASTHMA EMERGENCY

If **ANY** of the following occur:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or gray
- Skin on neck or chest sucked in with each breath

Student may also be anxious, restless and/or very tired.

Step 1: **Immediately** use fast-acting reliever inhaler (usually a blue inhaler).

CALL 911 for an ambulance. If possible, stay with person.

Step 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical help arrives.

While waiting for medical help to arrive:

✓ Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction)
✓ Stay calm, reassure the student and stay by his/her side ✓ Notify parent/guardian or emergency contact

THE LUNG ASSOCIATION™ Lung Health Information Line: 1-888-344-5864
www.on.lung.ca

ophea Healthy Schools Healthy Communities

District School Board of Niagara

ADMINISTRATIVE PROCEDURE

Copied from AP 3-12 (Appendix B)

AUTHORIZATION OF ADMINISTRATION OF ORAL/TOPICAL MEDICATION

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student			
Birthdate		**Grade**	
Address			
Postal Code		**Telephone**	
Parent's/Guardian's Name			
Business Address			
Postal Code		**Telephone**	

PARENT/GUARDIAN APPROVAL

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TO BE COMPLETED BY PHYSICIAN

Condition of Patient for which Oral/Topical Medication is Necessary	
Name of Medication	
Dosage or Amount to be Given Each Time	· As Indicated on Prescription Label
What Time(s) Dosage to be Given	· As Indicated on Prescription Label
Method of Administration (with Food?)	
Possible Side Effects	
Storage and Safekeeping Requirements for Medication	
Prescribing Physician's Name {Please Print}	
Office Address and Telephone Number	

Signature of Physician: _____ Date: _____

District School Board of Niagara

ADMINISTRATIVE PROCEDURE

Copied from AP 3-12 (Appendix A)

RECORD OF ADMINISTRATION OF ORAL/TOPICAL MEDICATION

Student's Name		**Grade**	
Name of Parent/Guaridan		**Telephone**	
Physician's Name		**Telephone**	
Medication			
Dosage			

Time	Day/Month/Year	Person Administering Medication	Comments (e.g. Side Effects)