Community Christian School

Medication Permit and Emergency Care Plan

Student'sName:_____DOB:_____

Teacher:_____Grade:_____

Physician Name:_____Phone:_____

Hospital Preference: _____

Mother's Name:_____

Work Phone: _____ Cell Phone: _____ Home Phone _____

Father's Name: _____

Work Phone: _____ Cell Phone: _____Home Phone _____

Alternate Emergency Contact: _____ Phone: _____

Medical Condition:_____

List allergen causing sever Anaphylaxis response (if applicable): _____

NOTEAdditional paperwork to be completed in the school office**

Location of Medication and other supplies: _____

Signs of severe reaction: _____

If a medication must be given during school hours, this form must be completed. The parent/guardian must provide the school with the FDA approved over-the-counter or prescription medication in it's original container with unexpired date which will be given as directed on the container or as directed by the physician. It is the responsibility of the parent/guardian to notify the school personnel of medication changes and to complete a new Authorization

Medications must be delivered to the school office staff according to Indiana Senate Bill No.376 (effective July 1, 2001).

Medications must be delivered in their original container and properly labeled with the student's name, name of medication, unexpired date, and instructions re: dosage, time/frequency of administration.

PROCEDURES FOR NON-PRESCRIPTION MEDICATION

All medication shall be administered in accordance with Indiana State Statue.

Written authorization/instructions by parent/guardian must accompany every medication that is given during school hours. Authorization must include:Name of student to be taking medication, Name of medication, Dosage (amount to be given), Time/Frequency (hour @ which medication to be given), Length of time which medication is to be given

PROCEDURES FOR PRESCRIPTION MEDICATION

A written order by a physician as well as written authorization must be provided for all prescription medication. The physician's instructions must include: Name of student to be taking the medication, Name of medication, Dosage (amount to be given), Route of administration, Time/frequency (hour @ which medication is to be given), Duration of administration

Whenever a change in medication, dosage, and/or frequency occurs, parent/physician authorization must accompany the new medication. Students, 4th grade and over, with a chronic disease/medical condition may possess and self-administer medication if the following conditions are met:

1) The student's parent/guardian annually files authorization with the student's principal for the student to possess and self-administer the medication AND
2) A physician annually states in writing that the student has a disease or medical condition for which the physician has prescribed medications, the student has been instructed in how to self-administer

the medication, and the nature of the disease/medical condition requires emergency administration of the medication.

PROCEDURES FOR SEVERE ALLERGIC REACTION TREATMENT

1) Administer Epinephrine injection or assist student with self-administration.
2) Call 911, informing emergency personnel that student has severe allergic reaction and that Epinephrine has been given.
3) Call parent or emergency contact.
4) Record administration or self-administration of medication in student's health record (including date, time, source of exposure, treatment, if EMS was called, and signature).
5) Emergency personnel are to transport to designated to designated hospital. If no hospital designated, transport to nearest hospital.

PLEASE NOTE: If Prescription, a copy of the prescription or signed doctor authorization is required for our files. Also, if samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

PLEASE LIST MEDICATIONS YOU ARE PROVIDING FOR YOUR STUDENT:

Medication_____Dosage_____Time/Frequency_____Duration_____

Prescription or Over the Counter (circle one)

Medication_____Dosage_____Time/Frequency_____Duration_____

Prescription or Over the Counter (circle one)

Medication_____Dosage_____Time/Frequency_____Duration_____

Prescription or Over the Counter (circle one)

Medication_____Dosage_____Time/Frequency_____Duration_____

Prescription or Over the Counter (circle one)

Special instructions:_____

Common Side Effects of Medication: _____

May student carry and self-administer medication due to a life-threatening condition (such as asthma, bee allergies, diabetes)?: _____yes _____no

My permission is hereby granted to the Community Christian School staff to assist my child in the administration of the above named medication in accordance with Community Christian School's medication policy. I hereby release and discharge Community Christian School and it's staff from any liability whatsoever that might result from administering or not administering medication.
\I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in at Community Christian School. This authorization expires as of the last day of the current school year.

Parent/Legal Guardian Signature_____ Date_____

Community Christian School does not retain paid medical personnel and retains the right to prohibit the administration of any drugs or procedures that appear to be beyond the ability of unlicensed school personnel. *IC:34-30-14-1*