Dear Parents,

Attached to this letter are copies of the Parent/Guardian Medication Consent Form and a Physician Order for Medication Form. **Please keep these forms in case you need them during the school year**. Additional forms are available in the School Office. Medication will **NOT** be given to your child if we do not have them on file.

Below is the medication policy from the Archdiocese of Milwaukee.

Administration of Medication to Students

1. No medication will be administered by school personnel without the Medication Consent Form and the Physician Order for Medication Administration Form being filled out and returned to the principal/school secretary.
   a. Medication Consent Form must be filled out by the parent/legal guardian and addressed and returned to the individual(s) administrating the medication and/or School Nurse.
   b. Physician Order for Medication Administration Form must be filled out by the prescribing physician and addressed and returned to the principal/school secretary.
   c. The School Office shall maintain an accurate medication file, which includes all of these necessary forms on each student receiving medication.
2. Medication to be given in the school must have the following information printed on the container:
   a. Child's full name
   b. Name of the drug and dosage
   c. Time to be given
   d. Length of time to be administered
   e. Physician's name
3. Medication will be taken by the child at the designated time administered by the Secretary and/or Principal. IT IS THE RESPONSIBILITY OF THE STUDENT, IF APPROPRIATE, NOT SCHOOL PERSONNEL, TO GET HIS/HER MEDICATION AT THE DESIGNATED TIME.

Asthma Inhalers

Schools recognize the importance and necessity of students being allowed to carry asthma inhalers. Students in grades K-12 may self-administer certain emergency prescription medications, such as inhalers and glucagons, while at school only under the supervision of school staff. An elementary student who carries an inhaler on his/her person will need to have an Archdiocese of Milwaukee release form completed and signed by the student's physician, parent/legal guardian, principal, and homeroom teacher. The form states that the student has been instructed in and understands the purpose, appropriate method and frequency of use of his/her inhaler. The school is absolved from any responsibility in safeguarding the student's inhaler. This Form can be obtained from the School Secretary.

4. Only limited quantities of any medicine are to be kept at school.
5. All medication administered at the school will be kept in the school office. NO MEDICATION, AT ALL (INCLUDING COUGH DROPS), IS TO BE KEPT IN THE CHILD'S CLASSROOM, OR ON THE CHILD'S PERSON. Parents sending a one-time dose of aspirin, cough syrup, etc. are to send this to the office along with a note giving permission to administer and instructions for the administration. TEACHERS ARE NOT TO BE ASKED TO ADMINISTER ANY MEDICATION, EXCEPT ON A FIELD TRIP AND THEN ONLY WITH WRITTEN PERMISSION FOR THE TEACHER IN CHARGE, TO ADMINISTER THAT ONE TIME DOSAGE.
6. The length of time for which a drug is administered, which is not to exceed the current year, shall be contained in the written instructions from the prescribing physician. Further written instructions must be received from the physician if the drug is to be discontinued or the dosage time changed from the original written instructions.
7. School personnel should not, UNDER ANY CIRCUMSTANCES, provide any non-prescription medicine to any student without meeting the criteria in 1 - 6 above, including the necessity of having written authorization from the student's physician.
8. An accurate and confidential system of record keeping will be established for each student receiving medication.
9. The principal/secretary may provide aspirin or other non-prescription medicine to students with written authorization from the student's physician and/or parents.

St. Dominic Catholic School
18105 West Capitol Drive
Brookfield, WI 53045
262-783-7565

PARENT/GUARDIAN MEDICATION CONSENT FORM
(Please type or print)

ALL MEDICATIONS MUST BE IN A ZIPLOC BAG WITH STUDENT'S NAME ON IT

Full name of child to be medicated: _____

Name of drug and dosage: _____
(Please be specific with dosage amount)

Hour(s) medication to be given: _____

Number of days to be taken: _____

Name of physician prescribing medication: _____

Physician's phone number: _____

Reason for medication: _____

I hereby give permission to the Health Room/Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

_____
Signature of Parent/Legal Guardian Date

_____
Address

_____
Home Phone # Work Phone #

Please return this form completed along with the medication(s) to the school office.

ARCHDIOCESE of MILWAUKEE

Form
5141.5(b)

MEDICAL PROVIDER AUTHORIZATION FORM
PRESCRIPTION MEDICATION

Student's Name:	DOB:
School:	Grade:
Diagnosis:	

DAILY MEDICATION

Medication:	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
1.						
2.						

AS NEEDED OR PRN MEDICATION

Medication:	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
1.						
2.						

MEDICAL PROVIDER CONSENT

I authorize the school to the give the above medication(s) to this student. **Asthma Inhalers and Epi-Pens Only:** This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self administer at school. Yes ☐ No ☐	
Print Medical Provider Name:	Date:
Medical Provider Signature:	

PARENT CONSENT

I give the school permission to administer the above medications as directed by the medical provider. Inhaler/Epi-Pen Only: My child may ☐ or may not ☐ carry and self-administer.	
Parent/Guardian Signature:	Date:

As part of the authorization form, school personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

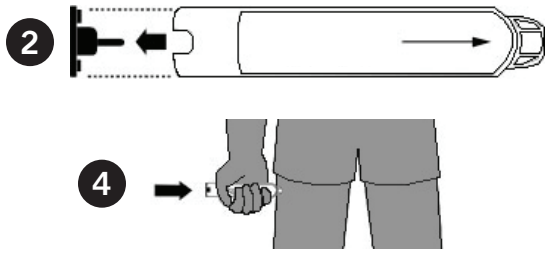
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

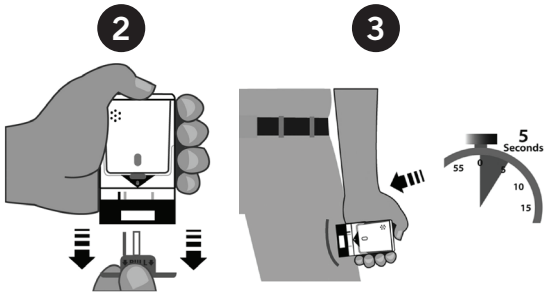
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014