**ALLERGY ACTION PLAN**

Please take to MD and bring/fax back to Nurse. 870-741-3339

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BOEP 5.504F2

**MEDICATION SELF-ADMINISTRATION CONSENT**

 **Student’s Name** (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_

* I have instructed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the proper way to use his/her inhaler and/or auto injectable medications. It is my professional opinion that he/she *should* be allowed to carry and use the medication by him/herself.
* It is my professional opinion that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *should not* carry his/her inhaler and/or auto injectable medication by him/herself.

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Authorizations**

The following must be provided for the student to be eligible to self-administer asthma inhalers and/or auto-injectable epinephrine. Eligibility is **only** valid for this school for the current academic year. This consent form must be renewed each year and/or anytime a student changes schools.

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* A written medical statement from a health-care provider who has prescriptive privileges that he//she has prescribed the asthma inhaler and/or auto-injectable epinephrine for the student and that the student needs to carry the medication on his/her person due to a medical condition;
* The specific mediations prescribed for the student;
* An individualized health care plan developed by the prescribing health-care provider containing the treatment plan for managing asthma and/or anaphylaxis episodes of the student and for medication use by the student during school hours; and
* A statement from the prescribing health-care provider that the student possesses the skill and responsibility necessary to use and administer the asthma inhaler and/or auto-injectable epinephrine.

Medications for self-medication shall be supplied by the student’s parent or guardian and be in the original container labeled with the student’s name. The parent or guardian shall provide the school with additional appropriate medication (use form 5.504F) for the school to have available to deal with an asthma or anaphylaxis emergency.

My signature below is an acknowledgment that I understand that the District, its Board of Directors, and its employees shall be immune from civil liability for injury resulting from the administration of medications by the student named above.

As Parent/Guardian I have reviewed this Care Plan for my child and agree with its contents. I also agree that this information may be shared with the Principal, Teachers and staff for awareness and preparedness in providing the best care for my child. I also agree to notify the school if any changes occur such as, change in medication, physicians or treatment. I agree that the school nurse may contact the physician named in this care plan to discuss this care plan.

Parent/Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campus Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Registered Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_