Teays Valley Local School District
385 Viking Way
Ashville, Ohio 43103

School Medication Guidelines

Scheduling of medication outside of school hours is encouraged. When that is not possible a specific policy must be followed. If your child needs to take prescription medication during school hours, please be aware written permission from the parent or guardian, physician's verification/authorization, and identification of the medication, dosage, and time interval it is to be taken.

All medication must be received in the container in which it was dispensed by the physician or pharmacist.

For over-the-counter medication, the student should bring the medication to the office in its original container and clearly marked with the student's name. Written permission from the parent will also be required before any over-the-counter medication is administered by a school employee. All medications will be kept in a locked cabinet in the school office/clinic, unless special circumstances justify an exception.

For prescribed medications, parents/guardians are responsible for the safe delivery of the medication to the school office. ***For controlled substances***- it is ***required*** that the parent/guardian or designated adult must bring in the medication to the school office and review with school staff. Specific instructions on how and when the medication is to be given will be reviewed at this time. Parents/guardians need to instruct the child as to the medication schedule and when the child is to report to the office. Parents will assume responsibility of notifying the school if the medication orders have changed.

Parents must understand that they are responsible for picking up any leftover or expired medication at school and that the medication will be disposed of on/after the last day of school if not collected by the parent- unless the parent has made specific arrangements with school personnel.

Medication forms are available in the school office or on the Teays Valley website at www.tvsd.us

The school physician will serve as health consultant and will provide written medication 'standing orders' for general and emergency care. In the event that a child needs NON-Prescription medication for minor ailments at school, the school nurse or her designee may dispense any of the following OTC medication under the guidelines of the school physician standing orders: Ibuprofen, Acetaminophen, Benadryl, Tums, Imodium A-D, Robitussin or First Aid/Antiseptic topical medication. This would be done with the parental signed permission, which would be indicated on the school emergency authorization form that is given to parents annually.

Thank you,
Teays Valley Nursing Staff

TEAYS VALLEY LOCAL SCHOOL DISTRICT

Medication Authorization Form

Injectable Medication

Name of student_____ DOB_____

Medication_____ Dosage_____

Route _____

Special Instructions

_____

For the treatment of:

____ Medical Diagnosis of:_____

____ Sting Allergy- specific insect if known _____

____ Food/Substance Allergy- Student may have an anaphylactic reaction to _____

_____

Symptoms of *anaphylaxis* for this Student: _____

_____

Possible side effects of this medication _____

NOTE: SCHOOL PERSONNEL WILL CALL 911 WHEN AN EPIPEN IS ADMINISTERED

Any additional emergency follow up:_____

Beginning date_____ Expiration date END OF SCHOOL YEAR

Physician's signature_____Date_____

Physician Printed Name/Address/Phone number

_____

_____

_____

REV 2/17

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Attach child's photo

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):_____ Dose: ☐ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

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DEDICATED TO THE HEALTH OF ALL CHILDREN™

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: (___) _____-_____

Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.