WEST OAKS ACADEMY SCHOOL'S AUTHORIZATION FOR MEDICATION AT SCHOOL

Year 20___ - 20___

Name of Student _____

Date of Birth _____ **Grade Level**: _____

Known Allergies:_____

_____

	DIAGNOSIS	**MEDICATION**	**DOSAGE**	**ROUTE**	**TIME TO BE GIVEN**
DAILY MEDICATIONS	__ADHD __seizure __diabetes other: _____				
EMERGENCY MEDICATIONS	**__Allergy** Allergen: _____ _____ _____ _____ ********** **__Seizures** ********** **__Diabetes**	__Diphenhydramine (benadryl) ---------- __Epi Pen ********** Med:_____ ********** ___Glucagon	__12.5 mg __25 mg other:_____ ---------- __0.15mg __0.3 mg ********** Dose:_____ ********** ___0.5mg ___1.0mg	By Mouth ---------- Injection ********** ____Nasal ____Rectal ********** Injection	__Upon exposure __Mild reaction ---------- __Upon exposure __Seere reaction __If provided, repeat dose after ********** ___At onset of seizure ___After 5 min ___After 10 min ********** If student becomes unconscious
ASTHMA	**___Exercise Induced** ---------- **___Asthma Yellow Zone** ---------- **___Asthma Red Zone**	___Albuterol ___Xopenex ---------- ___Albuterol ___Xopenex	___2 puffs ___1 vial ---------- ___2 puffs ___4 puffs ___1 vial ---------- **CALL 911** ___4 puffs ___1 vial	___Inhaler (spacer if provided) ___Nebulizer ---------- ___Inhaler (spacer if provided) ___Nebulizer ---------- ___Inhaler (spacer if provided ___Nebulizer	Before exercise as needed to prevent symptoms ---------- ___Every 4 hours as needed to relieve symptoms ---------- **FOR EMERGENCY SYMPTOMS**
PRN (AS NEEDED MEDS)					

WEST OAKS ACADEMY SCHOOL'S AUTHORIZATION FOR MEDICATION AT SCHOOL
Year 20___ - 20___

Contraindications for Administration: This medication is to be kept in a locked area and will be provided and transported to and from school by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, route, and the time it is to be given.) If an emergency occurs during the school day or if the student becomes ill, school officials should call parents, and 911. PARENT'S PERMISSION I hereby give permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

Parent or Guardian's Name: _____

Parent or Guardian's Signature: _____

Phone Number: _____ Date: _____

Reviewed by: _____ Date: _____

West Oaks Academy Administration _____

STUDENT ACKNOWLEDGMENT OF SELF-ADMINISTERED MEDICATION

(Inhaler only)

I understand and have demonstrated to the school administrator the skill level necessary to self-administer medication**. <u>I agree not to share medication or supplies with anyone</u>**.

Student Name: _____ Grade: _____

Student signature _____ Date: _____