Charlotte Mecklenburg Schools

Important Information about Medication Admininstration in CMS Schools (7/31/2017)

School Name	School Phone #	Fax:	For School Use Only
		(704) 432-2079 (School Health)	Date Received/Receiver's Signature: **Medication Received?** ☐ yes ☐ no
Student's Name (Please print.)	**Student's Date of Birth**		**Date Approved/Nurse's Signature** **Entered in EHR?** ☐ yes ☐ no
Parent/guardian completes this form when medications are ordered on a form that is not the "Medication Authorization for CMS Students (version 04/25/17 ml)". Parent/Guardian: Please read the information below. Fill in the contact information for your child's healthcare provider and parent/guardian contact information. Sign and date the form.			☐ **Medication in Health Room** ☐ **Student Self Carries** ☐ **Emergency Medication in Classroom**

Important Information about Medication Admininstration in CMS Schools

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.
- No medication will be given at school until the Medication Authorization form completed by the healthcare provider has been approved by a school nurse.
- Medications are given by a nurse or trained CMS staff.
- Unless changed in writing, medication orders will be used for the entire school year within which it was written.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.

Healthcare Provider's Name / Address / Phone / Fax	Parent/Guardian Contact Information (please print)	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools". I give permission for my child to receive the medications ordered by the healthcare provider during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about my child's medication(s) and health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking the medication(s) at school.

Write on line below.

Parent's/Guardian's Name (print) Signature Date

Charlote-Mecklenburg Schools

Mecklenburg County Health Dept

MECKLENBURG COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH

Emergency Action Plan and Order: Severe Allergy in School

Student's Name: ______________________________ DOB: ____________________
Student's Address: ____
Student's Phone #: ______________________ Student's I.D: ____________________
Mother's Name: ________________ Phone: Work _____________ Cell _____________
Father's Name: ________________ Phone: Work _____________ Cell _____________
Preferred Hospital: ____
School: __________________________ Teacher/Grade/Homeroom: _______________
School Year: _________________________________ History of asthma: ☐ Yes ☐ No

Student is known to be highly allergic to: ______________________________

Student's health care provider to complete the following information:

If ingestion of or contact with allergen is suspected; and/or if any of the following symptoms occur:

- tingling/itching/swelling of the lips, tongue, mouth, throat
- sense of tightness in the throat
- hoarseness, hacking cough
- repetitive coughing
- hives/itchy rash
- swelling around the face or extremities
- nausea, abdominal cramps, vomiting, diarrhea
- shortness of breath
- blue color/paleness to lips or nails
- wheezing
- "passing out"
- low blood pressure

Give medications immediately

a. ☐ Benadryl _______ mg by mouth **(Indicate dosage)**

b. ☐ EpiPen 0.3 mg IM OR ☐EpiPen Jr. 0.15mg IM **(Check one)**

If Epinephrine is given, call 911 immediately.

- Monitor vital signs.
- Call parent/notify school nurse/principal.

Other instructions:

Health Care Provider ____________________ **Phone #** ______________ **FAX #** _____________
Address: ____
Health Care Provider's signature: ______________________________ **Date:** _____________
(Please sign here to authorize this order and return to the School Health Program, MCHD, Hal Marshal Annex, 618 North College Street, Charlotte, N.C. 28202 Fax: 704-432-2079 Attn: School Health.)
Parent /Guardian Signature ___________________________________ **Date** ____________

School Health Nurse Signature ________________________________ **Date** ____________