



Administration of Medication during
SPEF Summer Program Hours

Please Read First - If your student is an SPUSD student and you have filled this paperwork out with the District, you can pick that paperwork up on the last day of school and bring it with you to Summer School or Summer Camps. SPEF cannot access this paperwork for you - the parent must bring it to us or a new form will need to be filled out.

Student's Name: _____

Birthdate: _____

Address: _____ Phone: () _____
Student's regular school site: ___Elem ___SPMS ___SPHS ___Non-SPUSD student

School Site of SPEF Summer Program: ___Elementary ___Intermediate ___High School

Diagnosis or purpose of medication:

Table with 5 columns: Medication, Strength, Dosage, Time Schedule, Route. Includes three empty rows for data entry.

Special instructions, precautions or possible side effects: _____

Student is knowledgeable of the actions/side effects, proper dosage and usage of the above medication. Student may carry the properly labeled prescription medication on his/her possession.

(Please initial the appropriate response).

___YES ___NO

Length of time medication is to be taken: _____

Name of Physician

Signature of Physician

Date

Administration of Medication in School

The following principles and procedures will be followed when a parent requests that a student be permitted to take medication at school.

1. Please provide medication in a sealed plastic bag with student's name, student's photograph for identification and valid medical consent form. Our office staff is trained in basic emergency procedures, however if your student is diabetic, our office is not able to test and provide insulin injections. As parents/guardians, you are responsible for making sure you have plans in place to manage your student's needs, for the safety of your student.
2. The administration of medication to students shall be done only in exceptional circumstance where the child's health may be jeopardized without it and only when such administration has been requested and approved by the student's parents/guardians and physician.
3. Only medication prescribed by the student's physician as being necessary to be taken by the student in the manner listed on this form should be brought to school.
4. All medications for students must be kept secure at the administrative or health office. Students may not carry medication on their person unless requested in writing by the physician.
5. A written statement shall be required of:
 - a. A family physician, who shall indicate the necessity for the medication being given to the student during school hours, and the method, amount and schedules for medication.
 - b. The parent, who shall request and authorize the designated school personnel to give the medication in the dosage so prescribed by the physician.
6. Form letter to parents/guardians and physicians are designed to facilitate these procedures and are to be completed on an annual basis.
7. Under no circumstances are school personnel to provide/administer over the counter medications to students without first obtaining written consent from the parent and physical.
8. At the end of the program must claim any medication remaining at school/camp or it will be disposed of by the school/camp admins.

To the Parent or Guardian: The prescribed medication must be delivered to the school health office in the **original pharmacy container** by the parent or guardian. High School students may bring their prescribed medication with this completed and signed form to the school health office.

Please sign the following statement: *I request that the school assist my child in taking the prescribed medication as directed above, and in accordance with the school policy.*

Name of Parent/Guardian

Signature

Date

SPEF Summer Program Emergency Health Care Plan

ALLERGIC REACTION TO: _____

Student: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Phones: 1) _____ 2) _____

FOR MILD ALLERGIC REACTION

Symptoms	What to Do
<ul style="list-style-type: none"> • Several Hives • Itchy Skin • Swelling at site if an insect stings or bites • _____ • _____ 	<ul style="list-style-type: none"> • Student must be accompanied to health office • Give _____ orally. <i>Antihistamine/Dose</i> • Stay with student • Keep student quiet • Monitor symptoms _____ • Contact parents

In some cases, symptoms may progress to a life threatening reaction.

FOR SEVERE ALLERGIC REACTION

Symptoms	What to Do
<ul style="list-style-type: none"> • Hives spreading over the body • Wheezing • Difficulty swallowing or breathing • Swelling of face or neck • Tingling/swelling of tongue • Vomiting • Shock <ul style="list-style-type: none"> ○ Pale/gray color ○ Clammy skin ○ Weak ○ Loss of consciousness 	<ul style="list-style-type: none"> • Administer EpiPen* (<i>Directions Below</i>) <ul style="list-style-type: none"> <input type="checkbox"/> EpiPen (<i>Physician, Please check appropriate one</i>). <input type="checkbox"/> EpiPen Jr. (<i>appropriate one</i>). • Call 911 immediately. (<i>EpiPen only lasts 20-30 minutes. Always call paramedics!</i>) • Contact parents or other emergency contact • Also give _____ orally <i>Antihistamine/Dose</i> • Stay with student • Keep student quiet • Monitor Symptoms

• Indicate here if student is capable of carrying/using own Epi-Pen. _____ Yes _____ No

• Location of EpiPen: _____ Locked med cabinet in Health Office. _____ Backpack
 _____ With Camp Admin _____ Other _____

****Directions for use of EpiPen:***

1. Pull off grey cap
2. Place black tip against upper outer thigh
3. Press hard into outer thigh until it clicks
4. Hold in place for ten seconds, then remove
5. Discard EpiPen in impermeable container and dispose of per school policy or give to emergency responder. (Do Not Return to Holder).

For SPEF use only when medication(s) are used: <input type="checkbox"/> _____ m mg given @ ____am/pm <input type="checkbox"/> EpiPen given @ ____ am/pm (circle am/pm)	Signed: _____ Dated: _____
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Physician's Signature: _____

Date: _____

Phone Number: _____

Physician's License # _____

Parent Signature: _____

Date: _____

School Clerk: _____

Date: _____