Endeavor Charter School

Physician's Plan of Treatment: Allergy

Name of Patient:_____ Birthdate:_____

Emergency Family Contact Numbers

(1) _____

(2) _____

Diagnosis: SEVERE ALLERGY TO_____

With the reaction/ingestion/exposure to_____

(1) Administer Benadryl _____ amount
(2) Contact family

Measures to be performed for emergency care if indicated:

(1) Observe closely for signs of generalized reaction such as: apprehension, flushing, generalized itching and burning, hives on face or chest, generalized swelling, wheezing or shortness of breath
(2) Administer injections of Epipen _____(dose) intramuscularly if above symptoms occur
(3) Call 911 and continue to monitor. Keep student calm.
(4) CPR should be initiated immediately for signs of cardio respiratory arrest.

Diet: Strict Avoidance of _____

Duration of order: School-year _____

Medications are kept in front office.

PHYSICIAN SIGNATURE:_____ **DATE:**_____

School Staff Instructed: **Date & Time:**

_____ _____

_____ _____

Parent Request and Physician's Order Form for Medication

To be completed by PARENT:

Child's Name:_____ Age:_____

I request that my child be administered the medication as indicated in the physician's order below. I understand that non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the medical staff of Endeavor Charter School to instruct designated staff in the administration technique. I understand that it is my responsibility to transport the medication to school and to make school personnel aware of the need to transport medication on extended field trips away from Endeavor.

I understand that:

(1) No employees and agents of Endeavor Charter School shall be liable in civil damages to any party for any act authorized or for any omissions relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
(2) Information shared may be in the form of an emergency/individual care plan for my child and may include information provided by my child's physician, myself, or from records that have been released to the school from another agency.
(3) Exchange of information will be limited to the minimum necessary to provide the required assistance for my child and will be shared only with those staff who may need to provide the specific assistance for him/her.
(4) This consent to release information must be signed before my child's teachers can provide assistance with special medical needs other than notifying parents and activating emergency services (911).
(5) I assume responsibility for notifying my child's teacher of my child's medical condition. I may request instruction by members of the medical committee of the Endeavor Board of Directors in a medical procedure or technique.

I authorize:
The release and exchange of medical information between my child's physician and any representative of Endeavor Charter School that is necessary in carrying out services for my child.

_____ _____ _____
Parent/Guardian Signature Emergency Contact Number #1 Date

_____
Emergency Contact Number #2

To be completed by PHYSICIAN:

_____ _____
Name and form of medication Dosage and time to be given

_____ _____
Symptoms to be given for Method of administration

Administration by: [] School personnel [] Student (please complete second page if student should carry or self-administer)

Significant side effects:_____ _____
Duration of order

_____ _____ _____ _____
Telephone Physician's Name (please print/type) Physician Signature Date

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To be completed by SCHOOL:
I am aware of the above student's medication requirements as noted above and will administer the medication as directed.

_____ _____
Endeavor Staff Signature Date

Endeavor Charter School

Authorization for Student to Carry and Independently Self-Administer Emergency Medication for Asthma and/or Anaphylaxis

(also complete first page)

Student Name: _____

To be completed by PHYISICIAN:

Diagnosis: _____

The student indicated above must have the medication(s) listed on the reverse side at Endeavor Charter School and during the entire duration of an extended field trip away from school. The student has been instructed in the treatment plan, self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for asthma and/or anaphylaxis. The student will not require adult supervision.

For Epi-Pen only:

[] In the event the student is experiencing anaphylaxis and is unable to administer the Epi-pen, a trained school staff member may administer the medication and call 911. I have discussed with the parent/guardian that a representative of the medical committee of the Endeavor Board of Directors will train designated school staff to administer the medication.

Telephone	Printed Physician's Name	Signature	Date
_____	_____	_____	_____

To be completed by PARENT:

I request and give permission for my child to carry and self-administer the medication as indicated in the physician's order during any time necessary at Endeavor Charter School or during an extended field trip away from school. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. Adult supervision will not be required.

I understand that:

(1) I shall provide the school back-up medication (in addition to what the student will carry) if it is necessary for my child, and that the teacher or his/her designee may carry this at school or on any extended field trip away from Endeavor.
(2) My child will be required to demonstrate the skill level necessary to use self-administered medications to a school designee trained by a representative of the medical committee of the Endeavor Board of Directors.
(3) My child will be subject to disciplinary action if medication is used in any other manner than that prescribed.

For Epi-pen only:

[] In the event my child is experiencing anaphylaxis and is unable to administer the Epipen, a trained school staff member may administer the medication and call 911. I give permission for a representative of the medical committee of the Endeavor Board of Directors to instruct designated staff to administer the medication in the event of an emergency if the student cannot. I understand that non-medical personnel will administer the medication.

Parent/Guardian Signature	Date
_____	_____

For SCHOOL USE only:

I certify that the student above has demonstrated adequate knowledge to responsibly self-carry and administer the medication listed above, and that the student has agreed to: (1) use the medication only as prescribed, (2) not allow any other person to use the medication, and (3) notify a school staff member if he/she is having more difficulty than usual with the listed health condition.

Endeavor Staff Signature	Date
_____	_____