Billings Catholic Schools
Faith, Family Spirit, Academic Excellence

HEALTH AND MEDICAL INFORMAITON

Student Name: _____ **Grade:** _____
(Please Print)

ALLERGIES TO: ☐ Bee Sting ☐ Food ☐ Environment ☐ Latex ☐ Medication ☐ Other _____

Name of Medication(s) _____

☐ Needs Medication at school ☐ Takes Medication at home

Describe reaction and intervention _____

List other allergies _____

ASTHMA: Name of medication(s) _____

☐ Needs medication at school ☐ Takes medication at home ☐ Carries inhaler on person ☐ Inhaler in office

ATTENTION DEFICIT DISORDER: Name of Medication(S) _____

☐ Needs medication at school ☐ Takes medication at home ☐ Diagnosed but not medication

DIABETES: ☐ Insulin dependent / needs school program set up ☐ Self manages snacks, diet, testing, coverage

HEADACHES: Name of medication(s) _____

SEIZURES: ☐ Needs medication at school ☐ Takes medication at home ☐ History of seizure but not currently on medication

OTHER MEDICATIONS: Diagnosis _____ Name of medication(s) _____

☐ Needs medication at school ☐ Takes medication at home

HEARING CONCERNS: Please explain _____

VISION CONCERNS: Please explain _____

PHYSICAL RESTRICTIONS: ☐ Uses mobility aide (wheelchair, walker, crutches, etc.)

☐ Restricted because of _____

☐ Must avoid this/these activities _____

OTHER: Describe health history (operations, serious accidents, and serious illness)

_____

_____

_____

DISEASES / CONDITIONS: If known, please indicate the year of the disease / condition when applicable:

☐ Chicken Pox ☐ Measles (Rubella) ☐ Mumps ☐ Rubella (3 Day) ☐ Scarlet Fever ☐ Sinusitis ☐ Eczema ☐ Whooping Cough ☐ Heart Disease
☐ Rheumatic Fever ☐ Kidney / Bladder Disorder ☐ Congenital Condition ☐ Other (please describe) _____

HOSPITAL SIGN OFF: **In case of an emergency, I authorize medical / dental care:** Please indicate hospital of choice _____

DOCTOR'S NAME: _____ **DENTIST'S NAME:** _____

NOTE: All items will require notification of the school nurse. If medication is needed, the parent must complete a medication authorization form before the first dose of medication can be given at school. This health concern information may be shared with school personnel as necessary to benefit the health and safety of this student and others. Please keep school staff informed as to changes to the information so the student's records can be updated as needed.

PARENT/GUARDIAN SIGNATURE (required): _____ **DATE:** _____

MEDICATION/TREATMENT AUTHORIZATION FORM

Prescribed Medication

Student's Name: Grade:

Date of Birth:

The following section is to be completed by the prescribing physician for prescription medication:

(A separate form must be completed for each medication or treatment prescribed)

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that non-medical staff may administer this physician prescribed service.

This order is effective from: **To:**

Diagnosis: (for this medication/treatment)		
Treatment:		
Name of Medication:	**Brand Name:**	**Generic Name:**
Strength (i.e. mg/tab)		

Instructions to assist the student in the self-administration of the medication

Amount (i.e. "2 tablets or 1 teaspoon"):		**Time(s):** (i.e. "10AM, Noon, and 2PM"):	
Frequency (i.e. "every 4 to 6 hours as needed for pain"):		**Duration** (i.e. "10 days")	
Route:	☐Oral	☐Topical	☐Inhaled
	☐*Injection* → → →	☐*Subcutaneous*	☐ *Intramuscular*
	☐Other *(describe)*		
Time medication is given at home *(if applicable)*:			
Possible side effects:			
Is student authorized to carry and use asthma inhalation medication or EpiPen?		☐ Yes	☐ No
Has student been instructed in the use of asthma inhaler or EpiPen?		☐ Yes	☐ No
The authorization for possession or self-administration of asthma, severe allergy, or anaphylaxis medication must be completed entirely by the parents and the physician for a student to be allowed to possess and/or self-administer asthma or severe allergy medication or an Epi-Pen.			
Other Information:			

Physician Signature: Date:

Physician Name:

Office Address: Phone:

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the administration or his/her designee to assist in the self-administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities. **It is my responsibility to notify the school if and when these orders change.**

Parent/Guardian name: Relationship:

Phone #: Phone #:

Signature: Date:

MEDICATION/TREATMENT AUTHORIZATION FORM

Over the Counter Medication

Student's Name: Grade:

Date of Birth:

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the administration or his/her designee to assist in the self-administration of the over-the-counter medication and/or treatment to my child while in school and away from school while participating in official school activities. **It is my responsibility to notify the school if and when these orders change.**

Over the Counter Medication Authorized:

Parent/Guardian Name: Relationship:

Phone #: Phone #:

Signature: Date:

Instructions to assist with the self-administration by the student of the over the counter medication:

Child's allergies:

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ALLERGY ACTION PLAN

PLACE CHILD'S PICTURE HERE

Student Name:_____ DOB:_____ Teacher: _____

ALLERGY TO: _____

Asthmatic ☐ YES *Higher risk for severe reaction ☐ NO

STEP 1: TREATMENT

Symptoms:		Give Checked Medication**: **To be determined by physician authorizing treatment**
▪ If a food allergen has been ingested, but *no symptoms*		☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat ❁	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung ❁	Shortness of Breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart ❁	Weakness, thread pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other ❁	_____	☐ Epinephrine ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ Epinephrine ☐ Antihistamine

❁ **Potentially life-threatening. The severity of symptoms can quickly change.**

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for instructions)

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or rescue squad _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor: _____ Phone number: _____
3. Parent: _____ Phone number(S): _____
4. *Emergency Contacts:*
   Name/relationship: _____ Phone number(S): _____

   Name/relationship: _____ Phone number(S): _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED,
DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Doctor's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

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EMERGENCY INFORMATION PROTOCOL

Student Name: _____ Date of Birth: _____

Date This Protocol is in Effect: _____ Diagnosis: _____

Mother: _____ Primary Phone: _____ Secondary Phone: _____

Father: _____ Primary Phone: _____ Secondary Phone: _____

Other Contact: _____ Primary Phone: _____ Secondary Phone: _____

Hospital Preference: _____ Pertinent Medical History: _____

_____

1. **IF YOU SEE THIS:** _____

DO THIS: _____

2. **IF YOU SEE THIS:** _____

DO THIS: _____

3. **IF YOU SEE THIS:** _____

DO THIS: _____

4. **IF YOU SEE THIS:** _____

DO THIS: _____

5. **IF YOU SEE THIS:** _____

DO THIS: _____

IF AN EMERGENCY OCCURS:

- Stay with the student---Never leave them alone
- Call or designate someone to call for assistance from the main office
- If the school nurse is unavailable, the following staff members are trained to deal with an emergency, and to initiate the emergency plan.

_____ _____

_____ _____

To be completed by parent:

I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff. I also allow school staff and/or the school nurse to share information regarding this treatment with the above physician if necessary.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse: _____ **Date:** _____