School:_____ School Year:_____

PHYSICIAN AND PARENT/GUARDIAN
AUTHORIZATION FOR EPI-PEN MEDICATION ADMINISTRATION

The Board of Education of Fayette County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug i n the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.

The undersigned Parent/Guardian does hereby consent to the intervention of the volunteer staff member in accordance with the Physician's instructions. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

PHYSICIAN ORDER FOR EMERGENCY ACTION PLAN

To be completed by the student's Physician and returned to the School Nurse.

STUDENT'S NAME: _____ **DOB:** _____

ALLERGEN: _____

STUDENT'S TYPICAL REACTION: _____

STUDENT'S OTHER KNOWN ALLERGIES: _____

ACTION TO BETAKEN:

1. If ingestion/exposure is suspected, give: _____ _____
Medication/Dose/Route

_____
Medication/Dose/Route

2. Call Rescue Squad (911) if Epi-Pen is used.
3. Notify Parent/Guardian or Emergency Contact.

I believe this student is able to carry and administer his or her own medication at the appropriate time and in the appropriate way. This student has been instructed on the indication for medication usage and methods of administration. Please check: Yes☐ No ☐

X _____
(Physician's Signature) (Physician's Name - Printed) Date Signed

_____ _____

PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication. See above and below.

PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent/Guardian of* _____ ***request that a *trained staff member administer*** *the above medication to the student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.*

☐ *I, the undersigned Parent/Guardian of* _____ ***give consent for **my student to self-administer*** *the above medication(s). I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance.* The School Nurse reserves the right to monitor the student periodically throughout the year. **** Parent/Student are responsible to have medication available at school. ** Self-Administered medication not provided or monitored by school staff.***

X _____ _____
(Parent/Guardian's Signature) Date Signed

REVIEWED BY: _____ ***RN*** ***DATE:*** _____

COPY TO: □ School Nurse
□ Teacher
□ Cafeteria Manager

Food Service Modification Form

This form must be completed and signed by a Physician if your student requires a dietary restriction.
(i.e. no peanut butter, no strawberries, etc.) **OR a food substitute** (i.e. allergic to cow's milk – substitute soy milk).
This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.)
This form must be completed and signed by the student's Physician to ***reverse*** **a previous accommodation** (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.) Once the form is on file, it will remain valid until a new form is presented.

PART A

Name of Student:		**Date of Birth:_____/_____/_____**	
Allergies:		**Is this Allergy Anaphylactic? YES NO**	
Current School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? Describe the major life activities affected. _____		**□ Yes**	**□ No**
Does student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed Physician.		**□ Yes**	**□ No**

PART B

List any dietary restrictions/allergies or special diet: _____

Food(s) to OMIT : □Fluid Milk □Cheese □Yogurt □Foods/recipes with milk or milk products as an ingredient

□Whole eggs (scrambled, hard boiled) □Food/recipes with any egg listed as an ingredient □Wheat/Gluten

□ Oats □Peanuts □Tree Nuts □Whole corn (corn kernel, tortilla chips, corn muffin, popcorn)

□NO foods/recipes with corn listed as an ingredient (corn syrup, cornstarch, etc.) □ Shellfish □Fish

□Other:_____ **For nutrition/ingredients for FCPS meals: www.fayette.nutrislice.com**

□ **List any foods to avoid for religious reason **** □ **Pork** □ **Gelatin**** ***Religious reason does not require Physician Signature***

□ **Food Intolerance:**_____ □ **Avoid Red Dye** □ **Avoid Lactose**

List foods to be substituted: _____

□**NO Substitutes required** **Please Substitute with** □ **Lactose Free** □ **Soy Free** □ **Sun butter**

Texture Modification:

Liquids:
- □ **Thin (Regular liquids)**
- □ **Nectar Thick**
- □ **Honey Thick**
- □ **Pudding Thick**

Solids:
- □ **Large foods cut into bite size**
- □ **Mechanical Soft (chopped)**
- □ **Mechanical Soft (ground)**
- □ **Pureed (Applesauce texture)**

List any special equipment or utensils that are needed:

Indicate any other comments about student's eating or feeding patterns:

Which meals will your student eat from the Cafeteria? □**Breakfast** □**Lunch** □**None** **(will bring from home)**

Parent/Guardian's Signature: _____	**Date:_____/_____/_____**
Physician's Signature: _____	**Date:_____/_____/_____**

REVIEWED BY NURSING: _____ ***RN*** ***DATE:*** _____