NORTH DAVIS PREPARATORY ACADEMY (NDPA) STUDENT MEDICAL FORM

SCHOOL YEAR: 20 _____ - _____

ID #: ________ ASPIRE: _____ MEDS IN OFFICE: _____

Student's Full Name: ___________________________________ **Age:** _____
Homeroom/Advisory: ___________________________________ **Grade:** _____
Parent/Guardian Full Name: ______________________________ **Phone #:** _______________

Please review this form in its entirety and complete ANY SECTION that applies to your student. This form must have all the required signatures and dates so we can coordinate appropriate care for your student while he/she is attending NDPA. If you have questions about this form, please contact the school office: ***K-4th (801) 547-1809 5th-9th (801) 336-3601.***

EMERGENCY CONTACTS

IF THERE IS A SERIOUS CONCERN, WHO IS THE FIRST PERSON YOU WOULD LIKE US TO CONTACT? If contacts listed below are not available, we will reference the emergency contacts on the student record. If no contacts can be reached, we will call 911.

1st CONTACT in case of emergency/concern: ________________________ Relationship: _______________
PHONE NUMBERS: Home: _______________ Cell: ______________ Work: ________________

2nd CONTACT in case of emergency/concern: __________________________ Relationship: _______________
PHONE NUMBERS: Home: _______________ Cell: ______________ Work: ________________

CONDITION INFORMATION

My student has the following condition(s):

Asthma Allergies* Diabetes Other (please specify): ________________________________

**Please specify allergy type(s):* ____
____

What age was your student diagnosed? _____ When was your student's last episode? ______________________

How often does your student have an occurrence? ______ Weekly ______ Monthly ______ Yearly

Check ALL signs your student shows when about to have an episode:

- ☐ Problems breathing
- ☐ Coughing
- ☐ Restlessness
- ☐ Loss of Consciousness
- ☐ Swelling: __________
- ☐ Anaphylaxis
- ☐ Wheezing
- ☐ Nausea
- ☐ Rash: _________
- ☐ Dizziness
- ☐ Listlessness
- ☐ Anxiety
- ☐ Flushed Skin
- ☐ Pale skin
- ☐ Other ________________________________
- ☐ Shortness of Breath
- ☐ Tightness in Chest
- ☐ Difficulty Swallowing
- ☐ Confusion/Slow Mental Response

EPISODE TREATMENT

How would you like NDPA to respond if an episode/difficulty occurs? ____________________________________
____

What usually helps your child if an episode/difficulty occurs? ____
____

MEDICATION INFORMATION

List all current medication(s) and delivery method *(example: Albuterol/Inhaler; Insulin/Injection; Benadryl/Oral)*:

Medication	Delivery method
___________________________	__________________________________
___________________________	__________________________________
___________________________	__________________________________

Additional information/concerns: ____
____

NDPA encourages pro-active self-management of health conditions by students who are capable of self-administration. In addition, we strongly advise parents/guardians to send a second "back-up" inhaler/epi-pen/insulin kit to keep in the office.

SECTION A

If you do not want to authorize your student to self-administer prescribed medication at school and do not want to authorize NDPA personnel to administer prescribed medication to your student during regular school hours, please complete the no authorization portion below and return it to the School.

NO AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION AT SCHOOL

NDPA has been pro-active in encouraging me to send the appropriate medication for my student's safety while attending NDPA. My signature below evidences my consent to NOT send such medication with my student or supply it to NDPA's office. I understand and consent that emergency protocol will be followed and 911 will be called in the event my student experiences a life-threatening medical emergency. I have instructed my student to notify NDPA staff immediately upon experiencing any difficulty with his/her medical condition/health management.

____ _______________________________________

Signature of Parent/Guardian *Date*

SECTION B

NDPA allows students to possess and self-administer prescribed medication at school if the following two conditions are met: (1) the medication in possession of the student is in a container properly labeled by a pharmacy, manufacturer, or health care provider; and (2) the student's parent/guardian and health care provider complete the Self-Administration of Medication Authorization below. If you want your student to possess and self-administer prescribed medication at school, please have both portions of the Self-Administration of Medication Authorization below completed and returned to the School.

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION

HEALTH CARE PROVIDER AUTHORIZATION

________________________________ (Student name) is under my care. I believe that it is medically appropriate for this student to self-administer the ☐ asthma, ☐ diabetes, and/or ☐ epinephrine (via an auto injector) medication described below and to be in possession of said medication at all times. The medication prescribed for this student is:

Name/Type of Medication(s):____

Dosage(s): ____

Possible Side Effects:____

____ _______________________________________

Signature of Health Care Provider *Date*

PARENT/GUARDIAN AUTHORIZATION

I authorize my student to carry and self-administer the medication described above consistent with Utah Code § 53A-11-602 (asthma), § 53A-11-604 (diabetes), and/or § 26-41-104 (epinephrine), as applicable. I acknowledge that my student is responsible for, and capable of, carrying and self-administering the medication described above.

My student and I understand there are serious consequences, which may include suspension, for sharing any medication with others. I have instructed my student to notify NDPA staff immediately when experiencing any difficulty with his/her medical condition/health management. I absolve NDPA and its employees, agents, representatives, and officers of any responsibility in safeguarding my student's medication described above and accept ultimate responsibility for monitoring the effects of the medication.

____ _______________________________________

Signature of Parent/Guardian *Date*

SECTION C

Designated and trained NDPA personnel may administer medication – except glucagon, epinephrine, and seizure rescue medication* – prescribed to a student during regular school hours if the following three conditions are met: (1) the medication is delivered to the School by the student's parent, guardian, or designated adult; (2) the medication is in container properly labeled by a pharmacy, manufacturer, or health care provider; and (3) the student's parent/guardian and health care provider complete the Authorization of School Personnel to Administer Medications below. If you want NDPA personnel to administer prescribed medication to your student during regular school hours, please have both portions of the Authorization of School Personnel to Administer Medications below completed and returned to the School.

AUTHORIZATION OF SCHOOL PERSONNEL TO ADMINISTER MEDICATIONS

HEALTH CARE PROVIDER AUTHORIZATION

_______________________________ (Student name) is under my care. The administration of the medication described below by NDPA employees during periods when the student is under the control of the School is medically necessary.

Name/Type of Prescribed Medication(s):____

Dosage(s)/Amount(s) to be Given: ____

Frequency/Times to be Administered: ____

Duration (week, month, indefinite, etc): ____

Anticipated Reactions to Medication(s) (symptoms, side effects for under dose/overdose, etc):________

____

____ ________________________________

Signature of Health Care Provider *Date*

PARENT/GUARDIAN AUTHORIZATION

My student **is not** capable of self-administering the medication described above. I hereby request and give my permission for my student to receive the specified medication as stated in the above instruction from the health care provider. Any discrepancy or change in administration requested by the parent/guardian requires written authorization from the health care provider stating the corrected or updated information regarding administration of medication. I understand that NDPA administration will designate specific staff to administer the medication during regular school hours, train staff, assure proper identification and safekeeping of the medication, and maintain records of such administration of medication.

I will supply said medication in a container properly labeled by a pharmacy, manufacturer, or health care provider to the designated NDPA staff members listed below**. I understand that NDPA will store the medication on premises and that it is my responsibility to keep the medication current throughout the school year and to pick it up on the last day of school. I understand that if my student is attending an off-site event, such as a field trip, I am responsible for making arrangements with the designated teacher regarding my student's care.

I further understand that NDPA personnel who assist in administering the specified medication and employers of such personnel are not liable, civilly or criminally, for any adverse reaction suffered by my student as a result of taking the medication or discontinuing the administration of the medication in keeping with the procedure outlined above.

____ ________________________________

Signature of Parent/Guardian *Date*

***See** Section D **for Glucagon Authorization and** Section E **for Epinephrine Auto Injector Authorization. A seizure rescue medication authorization must be handled through the student's Section 504 Accommodation Plan.

****Designated staff members are as follows:

Grades K-4:
Jean Britton (Secretary); Karyn Baker (Admin. Asst.)

Grades 5-9:
Candace Hamblin (Secretary); Lorie Cherone (Admin. Asst.)

SECTION D

NDPA personnel may administer glucagon prescribed to a student during regular school hours if the following four conditions are met: (1) the student's parent/guardian completes the Glucagon Authorization below; (2) NDPA personnel volunteer to be trained in the administration of glucagon medication and complete such training; (3) the student is exhibiting symptoms that warrant administration of glucagon; and (4) a licensed health care professional is not immediately available. If you want to authorize NDPA personnel to administer prescribed glucagon medication to your student during regular school hours, please complete the Glucagon Authorization below and return it to the School.

GLUCAGON AUTHORIZATION

I, the parent/guardian of the above named student, certify that glucagon medication has been prescribed for him/her. I request that NDPA identify and train school personnel who volunteer to be trained in the administration of glucagon medication in accordance with Utah Code § 53A-11-603. I authorize the administration of glucagon medication in an emergency to my student in accordance with Utah Code § 53A-11-603.

Parental Responsibilities

- The parent/guardian is to furnish the glucagon medication and bring it to the School in the current original pharmacy container bearing a pharmacy label with the student's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent/guardian, or other designated adult will deliver to the school and replace the glucagon medication within two weeks if the glucagon single dose medication is given.
- If the student has a change in his/her prescription, the parent/guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent/guardian will complete an updated Glucagon Authorization before the designated staff can administer the updated glucagon medication prescription.
- The parent/guardian will complete, sign and deliver a Self-Administration of Medication Authorization for diabetes medication if the student is to possess glucagon medication at all times.

I give permission for the School designee to contact my student's health care provider if clarification is needed to administer glucagon medication. I agree to meet the parental responsibilities listed above**. I give permission for NDPA personnel to release personal and medical information about my student if necessary in a health-related emergency situation.** I understand this completed and signed authorization form authorizes designated NDPA personnel to administer glucagon medication in emergency situations consistent with Utah Law.

____________________________________ ____________________________

Signature of Parent/Guardian *Date*

SECTION E

NDPA personnel may administer Epinephrine Auto Injector (EAI) medication prescribed to a student during regular school hours if the following four conditions are met: (1) the student's parent/guardian completes the Epinephrine Auto Injector Authorization on the next page; (2) NDPA personnel volunteer to be trained in the administration of EAI medication and complete such training; (3) the student is exhibiting potentially life-threatening symptoms of anaphylaxis that warrant administration of EAI medication; and (4) a physician is not immediately available. If you want to authorize NDPA personnel to administer EAI medication prescribed to your student during regular school hours, please complete the Epinephrine Auto Injector Authorization on the next page and return it to the School.

SECTION E CONTINUED . . .

EPINEPHRINE AUTO INJECTOR AUTHORIZATION

I, the parent/guardian of the above named student, certify that the epinephrine auto injector has been prescribed for him/her. I request that NDPA identify and train school personnel who volunteer to be trained in the administration of EAI medication in accordance with Utah Code § 26-41-104. I authorize the administration of EAI medication in an emergency to my student in accordance with Utah Code § 26A-41-105.

Parental Responsibilities

- The parent/guardian is to furnish the EAI medication and bring it to the School in the current original pharmacy container bearing a pharmacy label with the student's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent/guardian, or other designated adult will deliver to the School and replace the EAI medication within two weeks if the EAI single dose medication is given.
- If student has a change in his/her prescription, the parent/guardian is responsible for providing the newly prescribed information and dosing information as described above to the School. The parent/guardian will complete an updated EAI Injector Authorization before the designated staff can administer the updated EAI medication prescription.
- The parent/guardian will complete, sign and deliver a Self-Administration of Medication Authorization for EAI medication if the student is to possess EAI medication at all times.

I give permission for the School designee to contact my student's health care provider if clarification is needed to administer EAI medication. I agree to meet the parental responsibilities listed above. **I give permission for NDPA personnel to release personal and medical information about my student if necessary in a health-related emergency situation.** I understand this completed and signed authorization form authorizes designated school personnel to administer EAI medication in emergency situations consistent with Utah Law.

____ ___________________________________

Signature of Parent/Guardian *Date*

Please Note: NDPA will call 911 if EAI medication is administered.

SECTION F

If your student does not need medication at school, please complete the no medication needed portion below and return it to the School.

NO MEDICATION NEEDED

My student does not currently need medication. However, I have instructed my student to notify NDPA staff immediately upon experiencing any difficulty with his/her medical condition/health management.

____ ___________________________________

Signature of Parent/Guardian *Date*

PLEASE NOTE: In extreme cases, as NDPA determines it to be necessary and the School does not feel capable of administering aid OR the parents, guardians, or other emergency contacts cannot be reached, 911 *will* be called to administer aid to your student.

It is the responsibility of the parent/guardian, to ensure that student medications are kept up to date with all information provided including: administration, diagnosis, and consent.

Return by: ______________ to:

K-4th : North Davis Preparatory Academy
1765 W Hill Field Road Layton, UT 84041
Office 801.547.1809 Fax 801.547.1649

5th- 9th : North Davis Preparatory Academy
1591 W Hill Field Road Layton, UT 84041
Office 801.336.3601 Fax 801.336.3605

Additional Information: