SKAGGS CATHOLIC CENTER, LLC

300 East 11800 South, Draper, UT 84020
Juan Diego Catholic High School 801-984-7650-O, 801-984-7601-F Saint John the Baptist Middle School 801-984-7614-O, 1-801-984-7649-F Saint John the Baptist Elementary School 801-984-7108-O, 801-984-7122-F Guardian Angel Daycare 801-984-7135-O, 801-984-7122-F

Dear Parent/Guardian,

The following medical forms are available:

- Authorization to Administer Medication at School
- Asthma Self-Administration Form
- Epinephrine Auto Injector Authorization Form
- Allergy Form
- Glucagon Authorization Form

Please print and complete the form(s) that apply to your student; obtain your health care provider's signature (if applicable); and return the completed form(s) to the school. This process needs to be completed before any medication is given. If you would like to authorize your student to receive any over the counter medications (i.e. Ibuprofen and/or Tylenol), please complete the Authorization to Administer Medication at School form. New forms must be filled out at the start of each school year. If your student has a medical consideration, please contact the nurse to set up a health care plan prior to the start of the school year. All completed forms can be faxed, emailed, and/or brought to the school nurse.

If you have any questions you may contact me at:

Yolanda Gold RN BSN
School Nurse
801-984-7301 Office
801-984-7122 Fax
yolandagold@skaggscatholiccenter.org

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You have checked on school records that your child_____ has a severe or serious allergy. It is important to have annual health information to assist when he/she needs help at school.
Please complete this form and return it to the school.

CHECK ANY LIFE-THREATENING ALLERGY YOUR CHILD HAS:

Insect stings (list type)_____
Food (list type)_____
Animals/Other (list type)_____

INDICATE SIGNS THAT ARE USUALLY PRESENT DURING ALLERGY ATTACK:

- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Loss of consciousness
- ☐ Swelling:
  - How much?
  - Where?
- ☐ Rash
- ☐ Nausea
- ☐ Flushed or pale skin color
- ☐ Other (list)_____
  _____

Has emergency medical treatment been needed in the past year for allergies? ___No ___ Yes When? _____

Allergies are currently being treated by: Dr. _____ Phone number: _____

ARE MEDICATIONS NEEDED TO CONTROL THE ALLERGY(IES) ___NO ___YES List Medications below.

MEDICATION	AMOUNT TAKEN	TIME OF DAY

Please circle medications the student will be using at school. There must be both a parent and physician consent form signed for each medication given at school. Please notify the school nurse immediately of changes in dose and/or type of medication.

USUAL TREATMENT AT SCHOOL FOR A STUDENT HAVING A SEVERE ALLERIC REACTION IS TO:

1. Assist student with prescribed medication
2. Observe the student for inadequate breathing, signs of shock, unusual swelling and when observed call 911
3. Report to parent

Disclosure Statement

☐ I hereby give permission to the school nurse to share my student's medical information as needed with his/her teachers and support staff.

☐ I do not wish for my student's medical information to be shared with faculty and support staff. I understand it is my responsibility to inform the school nurse as well as school administration of this decision. My student's health and safety may be at risk not allowing this information to be shared.

_____
Parent Signature Date

_____
School Nurse Date

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Date_____

Epinephrine Auto Injector (EAI)
Authorization Form

In Accordance with Utah Code 53A-11-603 and 26-41, HB 101,2008 General Session

Name of Student _____Date of Birth_____
Grade_____

I _____ parent/guardian (circle one) of above student certify that the epinephrine auto injector has been prescribed for him/her. I request that the student's school identify and train school personnel who volunteer to be trained in the administration of Epinephrine Auto Injector (EAI) medication in accordance with Utah Code 53A-11-603 and 26 42, HB 101, 2008 General Session.

I authorize the administration of Epinephrine Auto Injector (EAI) medication in an emergency to the identified student with Utah Code 53A-11-603.

Parental Responsibilities:

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

I give permission for the school nurse or school designee to contact my child's healthcare provider if clarification is needed to administer Epinephrine Auto Injector (EAI). I agree to meet the parental responsibilities listed above. ***I give permission for school personnel to release personal or medical information about my child in a health-related emergency situation if necessary.*** *I understand this completed and signed form authorized school personnel to administer epinephrine in emergency situations consistent with Utah Law.*

Parent Signature _____ Date _____

Parent Phone Number _____ Parent Emergency Number _____

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Date _____

Utah Department of Health/Utah State Office of Education
Epinephrine Auto Injector (EAI) Medication Form
In Accordance with Utah Code 53A-11-603 and 26-41, HB 101, 2008 General Session

_____
Student Name Birth Date

_____
Address City State Zip

Health Care Provider Authorization

The above named student is under my care. I feel it is medically appropriate for the students to self-administer Epinephrine Auto Injector (EAI) medication, when able and appropriate, and be in possession of EAI medication and supplies at all times. The medication prescribed for this student is:

Name of Medication _____

Dosage_____

Possible Side Effects _____

_____
Signature of Health Care Provider Date

Parent/Guardian Authorization (mark all that apply)

- ☐ I authorize my child _____to carry prescribed Epinephrine Auto Injector (EAI) medication and supplies.
- ☐ I authorize appropriate/designated school personnel to maintain my child's medication for use in an emergency.
- ☐ I authorize my child to self-administer and carry the prescribed medication described above consistent with in Accordance with Utah Code 53A-11-603 and 26-41, HB 101, 2008 General Session.
- ☐ I do not authorize my child to carry and self-administer this medication. Please have appropriate/designated school personnel maintain my child's medication for use in an emergency.

My child and I understand there may be serious consequences, including suspension/expulsion from school, for sharing any medications and/or supplies with other students or school staff.

_____

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Utah Department of Health/Utah State Office of Education
ASTHMA SELF-ADMINISTRATION FORM
In accordance with Utah Code 53A-11-602

Student Name	Birth Date	Grade

Address	City	State Zip

HEALTH CARE PROVIDER AUTHORIZATION

The above named student is under my care. I feel it is medically appropriate for the student to self-administer inhaled asthma medication and be in possession of inhaled asthma medication at all times. The medication prescribed for this student is:
Name of Medication _____
Dosage_____
Possible Side Effects_____

_____
Signature of Health Care Provider Date

PARENT/GUARDIAN AUTHORIZATION

- ☐ I authorize my child_____ to carry and self-administer the medications describe above consistent with Utah Code 53A-11-602.
- ☐ I do not authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.
- ☐ My child and I understand there are serious consequences for sharing any medications with others.

_____
Signature of Parent/Guardian/Date

Emergency Contact Information:

Name:_____

Phone:_____

Date:_____

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Parent/Guardian
Authorization to Administer Medication at school
For Prescription and Over-the-Counter Medications including Ibuprofen and Tylenol

- I herby authorize St. John the Baptist Catholic School staff to administer only the medication described below to my child Name:_____Date:_____

- I understand that the medication is to be furnished by the parent and brought to the school in the original container. Each medication needs to be labeled with the child's name, medication name, time, dosage, and healthcare providers name.

- If there is a change in the prescription, a new parent consent form and new healthcare providers order must be completed before the staff can administer the new medication.

- Nurses and staff are *not* authorized to administer the first dose of an antibiotic because of concerns that the patient may experience an anaphylactic reaction.

- All medications must be delivered and picked up by an adult. All medications must be picked up within the last two weeks of the last dose given.

- I understand that by signing this form, I am giving permission to the school nurse to contact the healthcare provider if clarification is needed for administration of the medication(s) listed, and I am willing to meet all parental responsibilities.

  Parent/Guardian Signature:_____Date:_____
  Phone:_____

Health Care Provider
Authorization to Administer Medication at School

The above named student is in my care. The following medication(s) has been prescribed for the treatment
Diagnosis:_____
Symptoms:_____
Common Side effects can include:_____

Name of Medication	Dosage	Route	Time

Signature:_____Date:_____
This order can only be signed by MD, Dentist, Nurse Practitioner, Certified Physicians, or Registered Nurse

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Utah Department of Health/Utah State Office of Education
Glucagon Authorization Form
In accordance with Utah Code 53A-11-604

Student Name: _____
Date of Birth: _____
Name of School: _____
Grade: _____
Name of School District: _____

Health Care Provider Authorization
The above named student is under my care. The medication prescribed for this student to be used in an emergency is:

Name of Medication: Glucagon
Dosage: 1mg (1ml) Other _____
Possible Side Effects: nausea/vomiting

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____Date: _____

Parent/Guardian Authorization
I _____ parent/guardian (circle one) of the above student, certify that Glucagon medication has been prescribed for him/her. I request that the student's school 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 the student in accordance with Utah Code 53A-11-603.

Printed Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____Date: _____

EMERGENCY CONTACT INFORMATION:
Name: _____ Phone/Cell _____

Name:_____Phone/Cell _____