**THE MADDUX SCHOOL**
11614 Seven Locks Road ♦ Rockville ♦ Maryland 20854 ♦ 301-469-0223 ♦ www.madduxschool.org

# HEALTH INVENTORY INSTRUCTIONS

To Parents or Guardians:

In order for your child to begin each school year at The Maddux School, the following are required:

1. A physical examination by a physician or certified nurse practitioner must be completed within the past year. A physical examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene, your County of Residence or a licensed physician must be used to meet this requirement.

2. Evidence of screening for lead poisoning. A Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate DHMH 4620 may be used.

3. Evidence of immunizations against common childhood communicable diseases is required for all students. A Maryland Immunization Certification form or documentation printed at a licensed physician's office may be used. **The form documenting the required immunizations must be completed before a child may attend school.**

Exemptions from a physical examination and immunizations are permitted if they are contrary to a student's religious beliefs. Students may also be exempted from immunization requirements if a physician certifies that there is a medical contraindication.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

In order to assist your child in gaining the most from his/her educational experience, please complete Part 1 of this Health Inventory form. Part 2 must be completed by a physician or nurse practitioner, or attach a copy of your child's physical examination to this form. If your child takes medication of any kind at school or at home, you must have the physician complete the Physician's Medication Order Form. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the director of The Maddux School.

Please complete these health forms, **keep copies for your personal records** and return them to The Maddux School by the deadline noted.

## PART I - HEALTH ASSESSMENT

### To be completed by parent or guardian

**Child's Name:** _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

**Address:** _____
Number Street Apt# City State Zip

| Parent/Guardian Name(s) | Relationship | Phone Number(s) | | |
|---|---|---|---|---|
| | | W: | C: | H: |
| | | W: | C: | H: |

| Your Child's Routine Medical Care Provider | Your Child's Routine Dental Care Provider | Last Time Child Seen for |
|---|---|---|
| **Name:** | **Name:** | **Physical Exam:** |
| **Address:** | **Address:** | **Dental Care:** |
| **Phone #** | **Phone** | **Any Specialist :** |

**ASSESSMENT OF CHILD'S HEALTH -** To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

| | Yes | No | Comments (required for any Yes answer) |
|---|---|---|---|
| Allergies (Food, Insects, Drugs, Latex, etc.) | ☐ | ☐ | |
| Allergies (Seasonal) | ☐ | ☐ | |
| Asthma or Breathing | ☐ | ☐ | |
| Behavioral or Emotional | ☐ | ☐ | |
| Birth Defect(s) | ☐ | ☐ | |
| Bladder | ☐ | ☐ | |
| Bleeding | ☐ | ☐ | |
| Bowels | ☐ | ☐ | |
| Cerebral Palsy | ☐ | ☐ | |
| Coughing | ☐ | ☐ | |
| Communication | ☐ | ☐ | |
| Developmental Delay | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Ears or Deafness | ☐ | ☐ | |
| Eyes or Vision | ☐ | ☐ | |
| Feeding | ☐ | ☐ | |
| Head Injury | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Hospitalization (When, Where) | ☐ | ☐ | |
| Lead Poison/Exposure complete DHMH4620 | ☐ | ☐ | |
| Life Threatening Allergic Reactions | ☐ | ☐ | |
| Limits on Physical Activity | ☐ | ☐ | |
| Meningitis | ☐ | ☐ | |
| Mobility-Assistive Devices if any | ☐ | ☐ | |
| Prematurity | ☐ | ☐ | |
| Seizures | ☐ | ☐ | |
| Sickle Cell Disease | ☐ | ☐ | |
| Speech/Language | ☐ | ☐ | |
| Surgery | ☐ | ☐ | |
| Other | ☐ | ☐ | |

**Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?**

☐ No ☐ Yes, name(s) of medication(s):

**Does your child receive any special treatments?** (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

**Does your child require any special procedures?** (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

**I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____ _____
Signature of Parent/Guardian Date

## PART II - CHILD HEALTH ASSESSMENT
### To be completed *ONLY* by Physician/Nurse Practitioner

| **Child's Name:** Last First Middle | **Birth Date:** Month / Day / Year | **Sex** M ☐ F ☐ |
|---|---|---|

**1.** Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

**2.** Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

**3.** PE Findings

| **Health Area** | **WNL** | **ABNL** | **Not Evaluated** | **Health Area** | **WNL** | **ABNL** | **Not Evaluated** |
|---|---|---|---|---|---|---|---|
| Attention Deficit/Hyperactivity | ☐ | ☐ | ☐ | Lead Exposure/Elevated Lead | ☐ | ☐ | ☐ |
| Behavior/Adjustment | ☐ | ☐ | ☐ | Mobility | ☐ | ☐ | ☐ |
| Bowel/Bladder | ☐ | ☐ | ☐ | Musculoskeletal/orthopedic | ☐ | ☐ | ☐ |
| Cardiac/murmur | ☐ | ☐ | ☐ | Neurological | ☐ | ☐ | ☐ |
| Dental | ☐ | ☐ | ☐ | Nutrition | ☐ | ☐ | ☐ |
| Development | ☐ | ☐ | ☐ | Physical Illness/Impairment | ☐ | ☐ | ☐ |
| Endocrine | ☐ | ☐ | ☐ | Psychosocial | ☐ | ☐ | ☐ |
| ENT | ☐ | ☐ | ☐ | Respiratory | ☐ | ☐ | ☐ |
| GI | ☐ | ☐ | ☐ | Skin | ☐ | ☐ | ☐ |
| GU | ☐ | ☐ | ☐ | Speech/Language | ☐ | ☐ | ☐ |
| Hearing | ☐ | ☐ | ☐ | Vision | ☐ | ☐ | ☐ |
| Immunodeficiency | ☐ | ☐ | ☐ | Other: | ☐ | ☐ | |

**REMARKS:** (Please explain any abnormal findings.)

**4. RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature: _____ Date: _____

**5.** Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:
**(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).**

**6.** Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

| **7.** Test/Measurement | Results | | Date Taken | |
|---|---|---|---|---|
| Tuberculin Test | | | | |
| Blood Pressure | | | | |
| Height | | | | |
| Weight | | | | |
| BMI %tile | | | | |
| LeadTest Indicated:DHMH 4620 ☐ Yes ☐ No | **Test #1** | **Test#2** | **Test # 1** | **Test #2** |

**_____has had a complete physical examination and any concerns have been noted above.**

(Child's Name)

Additional Comments: _____

| Physician/Nurse Practitioner (Type or Print): | Phone Number: | Physician/Nurse Practitioner Signature: | Date: |
|---|---|---|---|
| | | | |

## MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

**Instructions**: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

### BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

### BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

**If all answers are NO, sign below and return this form to the child care provider or school.**

**Parent or Guardian Name** (Print): _____ **Signature**: _____ **Date**: _____

**If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.**

### BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

| Test Date | Type (V=venous, C=capillary) | Result (mcg/dL) | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

### BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

**********

**This part of BOX D must be completed by child's health care provider:** Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

## HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

## At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

**Allegany**
ALL

**Anne Arundel**
20711
20714
20764
20779
21060
21061
21225
21226
21402

**Baltimore Co.**
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

**Baltimore Co. (Continued)**
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

**Baltimore City**
ALL

**Calvert**
20615
20714

**Caroline**
ALL

**Carroll**
21155
21757
21776
21787
21791

**Cecil**
21913

**Charles**
20640
20658
20662

**Dorchester**
ALL

**Frederick**
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

**Frederick (Continued)**
21776
21778
21780
21783
21787
21791
21798

**Garrett**
ALL

**Harford**
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

**Howard**
20763

**Kent**
21610
21620
21645
21650
21651
21661
21667

**Montgomery**
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

**Prince George's**
20703
20710
20712
20722
20731

**Prince George's (Continued)**
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

**Queen Anne's**
21607
21617
21620
21623
21628

**Queen Anne's (Continued)**
21640
21644
21649
21651
21657
21668
21670

**Somerset**
ALL

**St. Mary's**
20606
20626
20628
20674
20687

**Talbot**
21612
21654
21657
21665
21671
21673
21676

**Washington**
ALL

**Wicomico**
ALL

**Worcester**
ALL

## Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

# MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

## RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

| Dose # | DTP-DTaP-DT Mo/Day/Yr | Polio Mo/Day/Yr | Hib Mo/Day/Yr | Hep B Mo/Day/Yr | PCV Mo/Day/Yr | Rotavirus Mo/Day/Yr | MCV Mo/Day/Yr | HPV Mo/Day/Yr | Dose # | Hep A Mo/Day/Yr | MMR Mo/Day/Yr | Varicella Mo/Day/Yr | History of Varicella Disease Mo/Yr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 | | | | |
| 2 | | | | | | | | | 2 | | | | |
| 3 | | | | | | | | | | Td Mo/Day/Yr | Tdap Mo/Day/Yr | MenB Mo/Day/Yr | Other Mo/Day/Yr |
| 4 | | | | | | | | | | _____ | _____ | _____ | _____ |
| 5 | | | | | | | | | | _____ | _____ | _____ | _____ |
| | | | | | | | | | | _____ | | | |

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE**.

**MEDICAL CONTRAINDICATION:**

**Please check the appropriate box to describe the medical contraindication.**

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

# How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

**Notes:**

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

# Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

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# MEDICATION ORDER FORM

Student: _____ Birthdate: _____

## 1. MEDICATION AT HOME: (To be Completed by Parent)

The following medications are administered at home:

| Medication | Dosage | Time Given |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**PARENT SIGNATURE:** _____ **DATE:** _____

## 2. MEDICATION AT SCHOOL: (To be Completed by Physician & Parent)

The following medications are to be given during school hours:

| Medication | Dosage | Time to be Given |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Route of Administration/Special Instructions: _____

_____

Side Effects: _____

_____ This order is in effect for current school year.
_____ This medication is only to be administered until _____
_____ This medication is discontinued as of _____

**PHYSICIAN'S SIGNATURE:** _____ **DATE:** _____

ADDRESS: _____ PHONE: _____

I hereby request and authorize The Maddux School personnel to administer prescribed medication as directed by the physician (Part 2 above). I agree to release, indemnify and hold harmless The Maddux School, Ivymount Corporation and any of their officers, staff members, or agents from lawsuit, claim, demand, or action, etc. against them for administering prescribed medication to this student, provided Maddux staff are following the physician's order as written in Part II above. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

**PARENT SIGNATURE:** _____ **DATE:** _____

Revised 11/25/2019

## INFORMATION AND PROCEDURES

1. Medication may not be accepted by school personnel without receipt of the Maddux Medication Order Form signed by both the parent/guardian and the authorizing physician.

2. Alternatively, physician may use office stationery or prescription pad to authorize medication administration. Required information includes: student name, birthdate, diagnosis, medication name, dosage, time to take medication, duration of medication, sequence if more than one medication is to be taken, side effects, physician signature, and date. The parent/guardian must sign and submit the parent portion of the Maddux form.

3. The first full-day dosage of any new medication must be given at home.

4. Please make sure we have a new form for each school year and each new or discontinued medication. Forms are good for one school year. They do not carry over from one school year to the next.

5. Parents are responsible for collecting any unused portion of medication within one week after expiration of physician order. Medications not claimed within that period may be destroyed.

6. All medications kept in school will be stored in a locked area accessible only to authorized personnel. Parents/guardian are to bring medications to school in a container appropriately labeled by the pharmacy. Medications may not be sent to school in a child's backpack. Parents are responsible for bringing and picking up all medications including over-the-counter medications.

7. A written physician's order form is also required for emergency medication, over the counter medication, and short-term medications, (including antibiotics).

8. Written orders from the physician will be needed any time there is a change in dosage, time of administration or discontinuation of a medication.

9. Evidence that the student is being monitored by a physician is required for psychostimulants, antipsychotic, antidepressants, anxiolytics, and seizure medication.

10. Parent or guardian will be notified via written note or email when a five-day supply of medication is left at school.

# THE MADDUX SCHOOL

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## EMERGENCY CARE FOR THE MANAGEMENT OF A STUDENT WITH A DIAGNOSIS OF ANAPHYLAXIS

Release and Indemnification Agreement for EpiPen® (Epinephrine Auto Injector)

### PART I: TO BE COMPLETED BY PARENT/GUARDIAN

I hearby request and authorize The Maddux School personnel to administer an Epinephrine Auto Injector as directed by the physician (Part II, below). I agree to release, indemnify, and hold harmless The Maddux School and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided The Maddux School staff are following the physician's order as written in Part II below. I am aware that the injection may be administered by a trained unlicensed staff member. I have read the procedures outlined on the back of this form and assume the responsibilities as required. I understand that the 911 rescue squad will always be called when an Epinephrine Auto Injector is administered, whether or not the student manifests any symptoms of anaphylaxis.

Student Name: _____ Birthdate: _____

Parent's authorization: _____ _____ _____
Name (Print) Telephone Signature & Date

**THIS PARENT MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR**

**TEACHER-CARRY/TEACHER-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

Teacher-carry/teacher-administration of student's **emergency** medication **must** be authorized by the parent and be approved by the school administrator according to The Maddux School medication policy.

Parent's authorization: _____ _____ _____
Name (Print) Telephone Signature & Date

### PART II: TO BE COMPLETED BY HEALTH CARE PROVIDER

In accordance with Maryland State Regulations, the Epinephrine Auto Injector may be administered by unlicensed Maddux School staff members that are trained by the school nurses. Unlicensed staff members are not allowed to wait for the appearance or observe for the development of symptoms before administering the Epinephrine Auto Injector.

1. Name of medication: Epinephrine Auto Injector (brand names include EpiPen® and Twinjet®)
   - Ana-Kit® will not be accepted for use at school.
   - Epinephrine Auto Injector will not be accepted for the management of asthma.
2. Reason for medication: For the management of acute allergic reactions to: Check (√):
   - ❒Stinging insects (bees, wasps, hornets, yellow jackets)
   - ❒Ingestion of (specify): _____
   - ❒Other allergen(s) (specify under what circumstances): _____
3. Medication is to be given: Check (√):
   - ❒If insect stings (bees, wasps, hornets, yellow jackets)
   - ❒Ingestion of (specify): _____
   - ❒Other allergen(s) (specify under what circumstances): _____
4. Route of administration for Epinephrine Auto Injector: Instramuscularly (IM) into anterolateral aspect of the thigh.
5. Dosage of medication: Check (√): one: ❒ Epinephrine Auto Injector 0.15 mg. ❒ Epinephrine Auto Injector 0.3 mg.
6. Repeat dose in 10 minutes if rescue squad has not arrived.* ❒Yes ❒No OR ❒Other _____
   *NOTE: For a repeat does, a second Epinephrine Auto Injector must be ordered and brought to school.
7. Side effects: Palpitations, rapid heart rate, sweating, nausea and vomiting

Health Care Provider: _____ _____ _____
Name (Print or Type) Telephone Signature & Date

### PART III: TO BE COMPLETED BY SCHOOL ADMINISTRATOR

❒ Parts I and II are completed, including signatures. It is acceptable if all items in Part II are written on the health care provider's stationery/prescription blank.

❒ Medication is properly labeled by a pharmacist. Epinephrine Auto Injector received: ❒1 device ❒2 devices

Reviewed by: _____ _____ _____
Name of School Administrator (Print) Telephone Signature & Date

# INFORMATION AND PROCEDURES

1. The Epinephrine Auto Injector **WILL NOT BE ADMINISTERED IN SCHOOL OR DURING SCHOOL-SPONSORED ACTIVITIES** without a parent/guardian-signed authorization and waiver and a physician's order/authorization.

2. This form must be on file in the student's health folder. The parent is responsible for obtaining the health care provider's order/authorization. (See Part II.) The school administrator will ensure that all items on the form are complete.

3. The parent is responsible for submitting a new form to the school each school year and whenever there is a change in dosage or a change in conditions under which the Epinephrine Auto Injector is given.

4. Medication must be properly labeled by a pharmacist and must match the health care provider's order. If the health care provider's orders include a repeat Epinephrine Auto Injector, an additional Epinephrine Auto Injector must be provided by the parent/guardian.

5. Medication must be hand-delivered to the school by the parent or, under special circumstances, an adult designated by the parent. Under no circumstances will a school staff member administer medication brought to school by the student.

6. All medication kept in the school will be stored in a secure area accessible only to authorized personnel.

7. Any unused medication will be collected by the parent within one day after the end of the school year.

8. In no case may the school staff member administer epinephrine to a student who is identified as subject to anaphylactic reaction outside the framework of the procedures outlined above.

9. Parental permission is necessary for teacher-carry/teacher-administered emergency medications such as **Epinephrine Auto Injector** for anaphylaxis. Maddux School staff will receive annual training in the safe and appropriate use of Epinephrine Auto Injector administration.

10. Anytime an Epinephrine Auto Injector is administered, 911 will be called.