

STUDENTS WITH SPECIAL HEALTH CARE NEEDS

EMERGENCY ACTION PLAN

Student:	Date of Birth:
Parent/Guardian Name(s):	
Phone (home/work/cell) #'s:	
Health Care Provider:	Phone:
Student Specific Emergencies:	

<i>If You See This:</i>	<i>Do This:</i>

IF AN EMERGENCY OCCURS:

1. If the emergency is life-threatening, initiate the plan as directed and call 9-1-1.
2. Stay with student or designate another adult to do so.
3. When calling for assistance from the school nurse and emergency personnel, state:
 - Who you are
 - Where you are
 - What the problem is
4. The following staff members are trained to deal with an emergency, and to initiate the appropriate procedures:

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Parent/Guardian(s) Signature:	Date:
Nurse Signature:	Date:

Dr. Robert J. Underwood
Superintendent

Indian Lake Schools

6210 SR 235 North
Lewistown, Ohio 43333
937-686-8601 • Fax: 937-686-8421

Coleen Reprogle
Treasurer

March 2022

Students with any medication to be stored or given at school such as daily, emergency or as needed, must provide the appropriate updated Medication Administration form each school year. There is a form for prescription medications that doctors sign and a different form for over the counter medications that parents simply sign when they drop off the medication for school.

Please note that Medication Administration Forms are also required for medications that students self-carry. Ohio law only lists 3 self-carry medications for school which include inhalers, epinephrine auto injector and glucagon. **ORC 3313.718** also states that in order for students to self-carry epinephrine auto injector, a second backup is to be received by the school. There is an area on the administration form for both the doctor and parent to sign consent for the student to self-carry these medications.

Remember students are not permitted to transport medications to/from school. A parent or guardian signature is necessary for medication to be signed in/out of clinic inventory. Finally, all medication **MUST** be stored in the original container with the label matching the signed doctor's order. For questions please contact District Nurse, Kourtney Thompson at 937-686-7323.

Sincerely,

Robert J. Underwood
Superintendent



Indian Lake Elementary School
8779 CR 91
Lewistown, Ohio 43333
Phone: 937-686-7323
Fax: 937-686-0049
Molly Hall, Principal
Pamela Scarpella, Asst. Principal

Indian Lake Middle School
8920 CR 91
Lewistown, Ohio 43333
Phone: 937-686-8833
Fax: 937-686-8993
Melissa Mefford, Co-Principal, Operations
Erin Miller, Co-Principal, Instruction

Indian Lake High School
6210 SR 235 North
Lewistown, Ohio 43333
Phone: 937-686-8851
Fax: 937-686-0024
Kyle Wagner, Principal
David Coburn, Asst. Principal

Indian Lake Local Schools

Medication Administration Form

(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name			Date of birth	
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication		Circumstance for use	
Dosage		Route	Time/Interval
Date to begin medication		Date to end medication	
Circumstances for use			
Special instructions			
Treatment in the event of an adverse reaction			
Epinephrine Autoinjector <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.			
Asthma Inhaler <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.			
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718			
a) To the student for whom it is prescribed (that should be reported to the prescriber)			
b) To a student for whom it is not prescribed who receives a dose			
Other medication instructions			
Does medication require refrigeration? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescriber signature		Date	Phone
Fax			
Prescriber name (print)			
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

<input checked="" type="checkbox"/> I authorize an employee of the school board to administer the above medication. <input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.			
<input checked="" type="checkbox"/> Medication form must be received by the principal, his/her designee, and/or the school nurse. <input checked="" type="checkbox"/> I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

<input type="checkbox"/> For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.			
<input type="checkbox"/> For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone