Health Conditions/ Medication at School

*****If your child is new to Randolph and has a health condition, or if your current Randolph student has developed a new health condition that we are not aware of yet, please contact Mrs. Wilson at** jwilson4@livoniapublicschools.org **or Mrs. Wehner at** awehner@livoniapublicschools.org **as soon as possible *before the first day of school*.**

Dear Families,

Please download the forms your child needs for school, based on their health conditions. New forms must be completed by you and your child's physician each year (dated after the last day of school of the previous school year). Please ensure that the forms include both your signature and your child's doctor's signature. We cannot dispense any medication without these completed forms.

****Note: A "Medication Authorization," which is included in the packets for each health condition, needs to be completed for each medication. Here's a quick link, if your child has more than one medication.*

- *Medication Authorization*

Life-Threatening Food and/or Insect Allergy

- *Allergy IHCP*
- *Medication Authorization*
- *Nut & Seed Restricted Lunch Table Guidelines*
- *Lunch Table Needs Lunchroom Addendum*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Asthma

- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Diabetes

- *Diabetes IHCP*
- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Seizure Disorder

- *Seizure IHCP*
- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Other

- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*
- *Contact Mrs. Wilson at jwilson4@livoniapublicschools.org or Mrs. Wehner at awehner@livoniapublicschools.org*

Please make sure that the forms are very specific. For example, if your doctor says the medication can be distributed "as needed," ask them to define a limit, such as "as needed up to three times in a school day."

It is our hope that all of the forms will be returned to Randolph (or Johnson for current 4th graders) on the first day of school. It is very important that we have all of this information on file in the office and distributed to the staff and teachers to keep your child safe. **Please drop off your child's completed Health Care Plan, Medication Authorization, and medication on the first day of school.**

If you have any questions or would like to set up a meeting to discuss your child's health care plan, please contact Mrs. Wilson at jwilson4@livoniapublicschools.org or Mrs. Wehner at awehner@livoniapublicschools.org (email is the best way to reach us). When school is open, you may also call the Randolph Office at (734) 744-2770 and ask for one of us.

Thank you so much for your support and have a wonderful summer!

Sincerely,

Mrs. Wilson & Mrs. Wehner
Randolph Elementary Support Teachers (ESTs)

INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name:
Health Concern: **ALLERGY -**
Date of Birth: Student ID:
Case Manager: Ext:

Click Here to Add Picture

Asthmatic: ☐ Yes* ☐ No * Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms

Give Checked Medication:
(determined by doctor authorizing treatment)

• If a food allergen has been ingested, but no symptoms:	☐ N/A	☐ Epinephrine	☐ Antihistamine
• MOUTH	Itching, tingling, or swelling of the lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• SKIN	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• GUT	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• THROAT†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• LUNG†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• HEART†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• OTHER†	_____	☐ Epinephrine	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine	☐ Antihistamine

† Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly (check one) ☐ Adrenaclick ☐ Auvi-Q ☐ EpiPen ☐ EpiPen Jr.

Antihistamine: _____
medication / dose / route

Other: _____
medication / dose / route

STEP 2: EMERGENCY CALLS

① Call 9-911 from a landline

② Call doctor _____ (Name of doctor) _____ (Phone) _____ (Fax)

③ Call _____ (Name) _____ (Relationship) _____ (Phone #1) _____ (Phone #2)

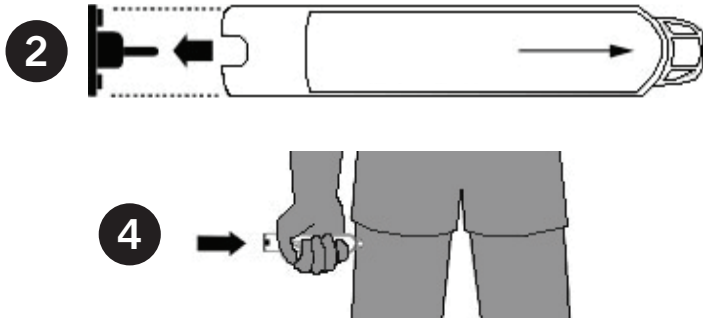
_____ (Name) _____ (Relationship) _____ (Phone #1) _____ (Phone #2)

The following individuals have reviewed this Health Care Plan and support its implementation.

_____ Parent / Guardian Signature Date
_____ Administrator Signature Date
_____ Doctor Signature (required) Date

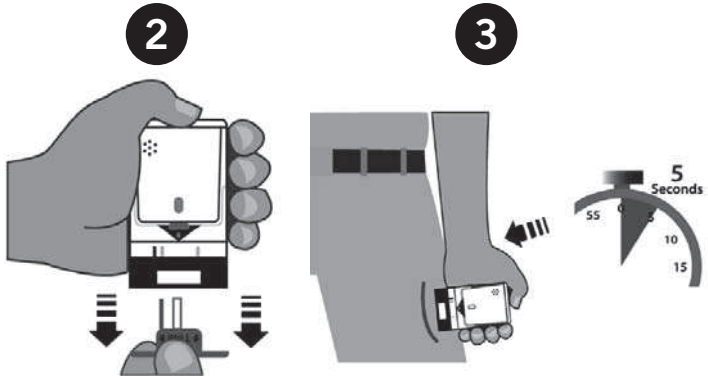
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

LIVONIA PUBLIC SCHOOLS

15125 Farmington Road ◆ Livonia, Michigan ◆ 48154

Medication Authorization

Student's Name _____ Date _____

Date of Birth _____ School _____

Teacher / Counselor _____ Grade _____

Both prescription and nonprescription medications require a completed Medication Authorization form signed by a physician and parent/guardian. If medication is related to a life-threatening health condition, Livonia Public Schools staff will develop an Individualized Health Care Plan in conjunction with the student's physician.

TO BE COMPLETED BY THE PHYSICIAN

Name of Medication _____ ☐ Prescription ☐ Non-Prescription

Reason for Medication _____

Form of Treatment ☐ Tablet / Capsule ☐ Inhaler ☐ Liquid ☐ Injection ☐ Nebulizer

Instructions _____

Dosage _____

Time of Day ☐ Daily ☐ As Needed ☐ Emergency Only ☐ Other -

If dosage is "as needed" or "emergency only" specify symptoms and limits: _____

Relevant Side Effects _____

Storage Requirements ☐ None ☐ Refrigerate ☐ Other -

Student is capable and responsible for self-possession and self-administering: ☐ Inhaler ☐ Emergency Meds

Please indicate if you have provided additional information: ☐ On the back of this form ☐ As an attachment

Physician's Name _____ Phone _____

Address _____ Fax _____

_____

_____ _____

Physician's Signature Date

TO BE COMPLETED BY THE PARENT / GUARDIAN

I request that _____
Student's Name

☐ receive the above medication at school according to district policy.

☐ be allowed to self-administer the above medication (inhaler or emergency medication) at school according to district policy.

☐ I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

_____ _____

Parent / Guardian's Signature Date

NOTES
① Medication includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin.
② Medications must be in an appropriately labeled container.
③ This authorization is valid for the current school year only.
④ This authorization must be maintained with the Individual Student Medication Log.
⑤ It will be the student's responsibility to make contact with school personnel for the administration of medication, unless other arrangements have been made by the administrator.

Revised 6/07

Nut-Restricted & Seed-Restricted

Lunch Table Guidelines

Dear Families,

You may request that your child sits at the Nut-Restricted and Seed-Restricted Lunch Table. The Nut-Restricted and Seed-Restricted Lunch Table is for those students who are allergic to any type of nuts and/or sesame seeds. In order to ensure the safety of all of our students with nut and/or sesame seed allergies, here are the guidelines for sitting at the Nut-Restricted and Seed-Restricted Lunch Table:

- Your child must bring his own lunch from home.
- Your child's lunch may not contain anything that contains nuts, sesame seeds, nut or sesame seed butter (no hummus or tahini, please), nut or sesame seed oils, or any derivative of the two. Please be aware that sesame seeds are often found on hamburger buns, on the crust of breads, on breadsticks, and in hummus. No sesame seeds or hummus, please.
- Your child's lunch may not contain any products that are manufactured in a facility that handles nuts or sesame seeds.
- Your child will not be permitted to buy anything off of the snack cart, except milk.
- If you would prefer that your child buys lunch, you will call Food Service at (734) 744-2820 to check the ingredients list of the food that your child would like to buy to ensure that your child does not consume anything that could be harmful to him or her at school. Our Food Service is not a nut-free food service or a seed-free food service, but they make every effort to not use nut products. Your child may not buy hummus because no hummus is allowed at the Nut-Restricted and Seed-Restricted Lunch Table.

Randolph Elementary is committed to keeping all of our students safe, and we thank you for your efforts in helping us reach this goal. If you have any questions, please contact Mrs. Wilson at jwilson4@livoniapublicschools.org or Mrs. Wehner at awehner@livoniapublicschools.org (email is the best way to reach us). You can also call the Randolph Office and ask for one of us at (734) 744-2770.

Sincerely,

Mrs. Wilson & Mrs. Wehner
Elementary Support Teachers (ESTs)

Nut-Restricted & Seed-Restricted Lunch Table Guidelines Contract

I, _____, the parent of

_____ understand and will follow the ***Randolph Nut-Restricted and Seed-Restricted Lunch Table Guidelines:***

In order to ensure the safety of all of our students with nut and/or seed allergies, here are the guidelines for sitting at the Nut-Restricted and Seed-Restricted Lunch Table:

- Your child must bring his own lunch from home.
- Your child's lunch may not contain anything that contains nuts, sesame seeds, nut or sesame seed butter (no hummus or tahini, please), nut or sesame seed oils, or any derivative of the two. Please be aware that sesame seeds are often found on hamburger buns, on the crust of breads, on breadsticks, and in hummus. No sesame seeds or hummus, please.
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Parent Signature_____Date_____

Please return this form to Mrs. Wilson & Mrs. Wehner's mailbox in the Randolph office. Thank you!

Individualized Health Care Plan (IHCP)
Lunchroom Addendum:
NUT-RESTRICTED & SEED-RESTRICTED LUNCH TABLE

I, _____ (Parent/Guardian's Name—Please print.), the parent/guardian of _____ (Child's Name—Please print.), have the following lunchroom guidelines for Randolph Elementary attached to my child's IHCP:

_____My child always eats lunch at the designated ***Nut-Restricted & Seed-Restricted*** **lunch table**.

_____My child is permitted to eat lunch with his/her peers at ***any*** **of the lunch tables**.

Parent Signature _____ *Date*_____

*Teacher Signature*_____ *Date*_____

*Administrator Signature*_____ *Date*_____

Child's Name:_____

Parent's Name:_____

Parent Medication Drop Off

Please put a check on each line, once you confirm that the following information is true:

_____ 1. I have checked the expiration dates on the medication I am turning in to make sure that they will NOT expire during this school year. If that is not possible, I have marked my calendar to remind myself to bring new medication to school before the old one expires.

_____2. I have a Medication Authorization completed for EACH medication I am turning in to the Randolph office.

_____3. I have checked to make sure that the name of the medication I am giving Randolph matches the name on the Medication Authorization form (and the Health Care Plan, if the child has one). (For example, we cannot accept an EpiPen if the doctor listed Auvi-Q.)

_____4. There is a prescription label with my child's name on it for every prescription medication I am giving Randolph.

_____5. If I am giving Randolph prescription pills, I have counted to make sure that the number of pills in the bottle matches the number of pills on the prescription label typed in by the pharmacist.

_____6. I am giving Randolph every medication that is listed by the doctor on the Health Care Plan (if my child has a Health Care Plan).

_____7. I have made sure that the doctor signed every form I am giving Randolph.

_____8. I have signed and dated every form I am giving Randolph.

_____9. If my child has a nut or seed allergy, I have completed the Lunchroom Addendum.

_____10. If I have requested my child to sit at the Nut-Restricted & Seed-Restricted Lunch Table, I have signed the Nut-Restricted and Seed-Restricted Lunch Table Guidelines Contract.

_____11. I have provided my email address and phone number where I can be contacted for questions.

email address:_____ phone number:_____

Please return this form to the Randolph office when you drop off your medications and your forms. Thank you!

Parent Signature_____ Date_____

2019-2020

Randolph Elementary School

Livonia Public Schools
14470 Norman Street, Livonia, MI 48154
Phone: 734.774.2770 Fax: 734.744.2772

Mike Daraskavich, Principal

Dear Parents:

It is recognized that certain medications may be necessary and must be prescribed at certain times of the day. In many instances, the administration of medication can be adjusted to avoid the necessity of administration during school hours. However, there may be instances when medication must be administered to your child during school hours.

When medication is necessary during school hours:

1. It may be necessary and appropriate for a parent or guardian to administer medication to his/her child. Please contact the school office to make appropriate arrangements.
2. If school personnel will be administering medication, the accompanying Medication Authorization form must be completed by the student's physician and parent or guardian and returned to the school office before administration of medication. This authorization is valid for the current school year only.
3. It will be the student's responsibility to make contact with the designated staff member for the administration of medication unless other arrangements have been agreed to by the building principal.
4. "As needed" medication requires a physician's statement specifying dosage limits.
5. All medications to be administered at school must be in an original appropriately labeled container. (Must specify student name, medication name, frequency, and dosage to be given.)
6. Both prescription and nonprescription medications require a completed physician and parental/guardian authorization form.
7. All medications that are to be administered by school personnel must be brought to school and immediately turned in the school office. Inhalers or medication for life threatening situations may be maintained by the student or in other locations as approved by the building administrator.
8. All controlled-substance medications (defined as drugs regulated by the Federal Controlled Substances Acts, including opiates, depressants, stimulants, and hallucinogens) will be counted and recorded upon receipt with the parent/guardian.
9. Medication left over at the end of the school year, or after the student has left the district, shall be picked up by the parent/guardian. If this is not done, the individual who administers the medication will dispose of the medication and record this disposal on the medication log.
10. Individual exceptions to these procedures must be approved by the building principal.

Thank you for your cooperation. If you have any questions or concerns, please contact your building principal.

Sincerely,

Michael Daraskavich
Principal, Randolph Elementary

We Are A Leader In Me School! The 7 Habits of Randolph Leaders:

Be Proactive (You're in Charge) - - - Begin With The End In Mind (Have a Plan)
Put First Things First (Work First, Then Play) - - - Think Win-Win (Everyone Can Win)
Seek First to Understand, Then to Be Understood (Listen Before You Talk) - - - Synergize (Together Is Better)
Sharpen the Saw (Take Care of Yourself)