McIntosh High School bands
MEDICATION FORM

Dispensing Guidelines:

- Prescription and over the counter medications must be in original containers.
- Prescription medications must be checked in and out with the First Aid Committee Chair
- Prescription and over the counter medications will not be left unattended.

Student Name:	
Student Date of Birth:	
Drug Allergies:	
Please Circle one option:	
Student MAY be given OTC medications	Student MAY NOT be given OTC medications
Parent/Guardian Name(s):	
Work Phone:	Cell Phone:
Parent/Guardian Signature:	

If you will be providing medication, please fill out the box(es) below.

Medication Information *–each medication must be listed separately.*

Please circle: Over the Counter Medication or Prescription Medication
Medication #1 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

Please circle: Over the Counter Medication or Prescription Medication
Medication #2 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

Student Name: ____

Please circle: Over the Counter Medication or Prescription Medication
Medication #3 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

Please circle: Over the Counter Medication or Prescription Medication
Medication #4 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

Please circle: Over the Counter Medication or Prescription Medication
Medication #5 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

Please circle: Over the Counter Medication or Prescription Medication
Medication #6 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

Please circle: Over the Counter Medication or Prescription Medication
Medication #7 Name of Medication:
Reason for Use:
Directions for use (dose and time):
Special dispensing directions:

McIntosh High School Band
Anaphylaxis Emergency Action Plan

NAME: ______________________________ AGE: __________

ALLERGY TO: ______________________________

Asthma: ☐ Yes (high risk for severe reaction) ☐ No

Other Health problems besides anaphylaxis: ______________________________

____

Concurrent medication, if any: ______________________________

____

SYMPTOMS OF ANPHYLAXIS INCLUDE:

MOUTH:	**itching, swelling of lips and/or tongue**
THROAT*:	**itching, tightness/closure, hoarseness**
SKIN:	**itching, hives, redness, swelling**
GUT:	**vomiting, diarrhea, cramps**
LUNG*:	**shortness of breath, cough, wheeze**
HEART*:	**weak pulse dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
***Some symptoms can be life-threatening! ACT FAST!**

WHAT TO DO:

1. INJECT EPINEPHRINE IN THIGH USING: ☐EpiPen Jr. (0.15 mg) ☐ Twinject (o.15 mg) ☐EpiPen Jr. (0.3 mg) ☐ Twinject (0.3 mg)

Other medication/dose/route: ______________________________

IMPORTANT: ASTHMA PUFFERS AND/OR ANTIHISTAMINES CANNOT BE DEPENDED ON IN ANAPHYYLAXIS!

2. CALL 911 or RESCUE SQUAD *(BEFORE CALLING CONTACTS)*!

3. EMERGENCY CONTACTS:

Emergency contact #1:	home__________	work __________	cell __________
Emergency contact #2:	home __________	work __________	cell __________
Emergency contact #3:	home__________	work __________	cell __________

DO NOT HESITATE TO GIVE EPINEPHRINE!

COMMENTS: ______________________________

____

______________________________ ______________________________

Doctor's Signature/Date Parent's Signature (for individuals under 18 years)/Date

Adapted from J Allergy Clin Immunol 1998; 102: 173-176 and J Allergy Clin Immunol 2006; 117: 367-377

Updated 12-2008

McIntosh High School Bands
Asthma Action Plan

To the Parents/Guardians of:

____
Student's Name

If your student experiences asthma episodes, please fill out the following form. Since this is a serious and potentially life-threatening condition, the band needs information to insure the correct reaction is taken during an asthma episode.

Please describe the nature, approximate frequency and severity of the episodes:

____

____

____

Peak Flow:

____

____

____

Triggers:

____

____

____

Steps for an acute asthma episode (as recommended by physician):

1 ____

2 ____

3 ____

4 ____

Parent's Guardian's Signature: ______________________________

Date: ______________________

Updated 12-2008