Appendices

Missing Child Educational Program

The School incorporates materials from the Ohio Attorney General Missing Children Clearinghouse, including the most recent Annual Report generated by the Clearinghouse, and resources from the National Center for Missing and Exploited Children into its informational program about missing children available to students, parents and community members.

For more information regarding child safety, please visit http://www.missingkids.com/Resources or http://www.ohioattorneygeneral.gov/missingchildren.

R.C. 3313.96(B).

Form for Reporting Incidents of Harassment, Intimidation, and Bullying

Incident Reporter: _____

Date: _____

Victim(s): _____

Approximate time of prohibited incident: _____

Place of prohibited incident: _____

Additional witnesses of prohibited incident: _____

_____

Description of prohibited incident observed: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Reporting Person: _____

*Reports should be submitted in the locked box located in the School office.

Notice to Parents Regarding Medication Policy

To: Parents
From: _____
Date: _____
Subject: Medication Policy

To protect your child's safety, the school nurse and/or health aide (as designated by the Principal) will adhere to the following medication policy. It is required that **BOTH** parent's **AND** physician's signature are on file before any prescription **OR** non-prescription medication is administered. This includes all medications, even such over-the-counter products as Tylenol, Advil, Dimetapp, etc.

Although this may cause some inconvenience, we feel that this policy is best for the continued protection of your child, and must be followed. **If we do not have your written permission and the written permission of your physician, the medication will not be given.** Permission forms can be obtained by contacting your school nurse or health aide or the school office.

In order for your child to receive any medication at school, please conform with the following:

- A written request must be obtained from the doctor and the parent/guardian. **See Appendix 402-A for required information.**
- The medication must be in its original container and have a fixed label which indicates the student's name, name of medication, dosage, method of administration, and time of administration.
- When the empty prescription bottle is returned to you, please send the refill to school promptly.
- The medication and the signed permission forms must be brought to the school by the parent or guardian.
- Wherever possible, please include a photo of your child with the permission form.
- New permission forms must be re-submitted each school year and are necessary for any changes in medication orders.
- If your child is taken off medication, will no longer receive it at school, or if the prescription otherwise changes, please provide a dated, written note of such change as soon as possible. If medication is not picked up from the health aide or school office within ten (10) days, it will be properly disposed.

Please contact the Principal or his/her designee if you have any questions. Thank you for your cooperation.

Physician's Request for Medication Form

SECTION I – TO BE COMPLETED BY PARENT (OR GUARDIAN, CARETAKER)

The following Student is under my care and should receive the medication indicated below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and, therefore, it must be taken during school hours.

I agree to notify the School if I change physicians or if the prescription is changed or eliminated. I will deliver the medication to the School in its original container. I understand that it is the Student's responsibility to report on time for this medication.

Name of Student: _____

Address: _____

City/State/Zip: _____

School: _____ Grade: _____

Parent Name: _____ Signature: _____

SECTION II – TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER

Name of Prescribed Medication: _____

Date of Authorization: _____ Dosage: _____

Times/Intervals To Be Administered: _____

Begin/End Dates: _____

Adverse or severe reaction that should be reported to physician: _____

_____

Special Instructions for Administration/Storage of Medication: _____

_____

Name: _____ Phone Number: _____

Signature: _____ Date: _____

SECTION III – TO BE COMPLETED BY SCHOOL

The following school personnel have read this form and are authorized to administer medication to the student as outlined.

Name_____ Signature_____ Date_____

Name_____ Signature_____ Date_____

Name_____ Signature_____ Date_____

Inhaler Permission Form

All sections must be completed. Completed form must be submitted to the Principal or his/her designee and the School Nurse, if the School has one assigned.

To be Completed by the Physician

Student Name: _____

Student Address: _____

The above-named Student has the approval to possess and use the following inhaler medication to alleviate asthmatic symptoms. Use must be in accordance with the following specifications: _____

_____

Name and dose of medication: _____

Date the administration of the medication is to begin: _____

Date, if known, administration of medication is to cease: _____

The following procedure is to be employed in the event that the medication does not produce the expected relief from an asthma attack: _____

_____

Please list any severe adverse reactions that may occur to the student using the inhaler that should be reported to the physician: _____

_____

Please list any severe adverse reactions that may occur to another student, for whom the inhaler is not prescribed, should such student receive a dose of the medication: _____

_____

Any other special instructions: _____

_____

Physician Signature: _____

Physician Name (Printed): _____

Physician Address: _____

Emergency Telephone Number: _____

To be Completed by a Parent or Legal Guardian

I, as the parent or legal guardian of the above-named Student, do hereby give my approval for this Student's possession and use of the inhaler medication described above.

Parent/Guardian Signature: _____

Parent/Guardian Name (Printed): _____

Name and emergency telephone number of a parent or guardian, or other person having care or charge of this Student in an emergency: _____

_____

Epinephrine Autoinjector Permission Form

All sections must be complete. Completed form must be submitted to the Principal or his/her designee and the School Nurse, if the school has one assigned.

To be Completed by the Physician

Student Name: _____

Student Address: _____

Use of the epinephrine autoinjector must be in accordance with the following specifications: _____

Name and dose of medication: _____

Date the administration of the medication is to begin: _____

Date, if known, administration of medication is to cease: _____

Circumstances in which the autoinjector should be used: _____

The following procedure is to be employed in the event that the student is unable to administer the medication or the medication does not produce the expected relief from anaphylaxis: _____

Please list any severe adverse reactions that may occur to the student using the epinephrine autoinjector that should be reported to the physician: _____

Please list any severe adverse reactions that may occur to another student, for whom the epinephrine autoinjector is not prescribed, should such student receive a dose of the medication: _____

Any other special instructions: _____

By signing below, I acknowledge that the Student is capable of possessing and using the autoinjector appropriately and have provided the Student with training in the proper use of the autoinjector

Physician Signature: _____

Physician Name (Printed): _____

Physician Address: _____

Emergency Telephone Number: _____

_____

To be Completed by a Parent or Legal Guardian

I, as the parent or legal guardian of the above-named Student, do hereby give my approval for this Student's possession and use of the epinephrine auto injector medication described above.

Parent/Guardian Signature: _____

Parent/Guardian Name (Printed): _____

Name and emergency telephone number of a parent or guardian, or other person having care or charge of this Student in an emergency: _____

FOOD ALLERGY NOTIFICATION FORM

(ONLY ONE CHILD PER FORM)

Date: _____

Parent/Guardian: _____

Student: _____

1. _____ (Student) has an allergy to _____.

2. This allergy is _____ or is not _____ potentially life threatening. If potentially life threatening:

   Action to be taken: _____

   _____

   Medications to be taken: _____

   _____

I certify that I have completed an Emergency Medical Authorization Form.

I have consulted with the School to make a Food Allergy Action Plan and I have trained my child as to his/her needs and safety. We will review the weekly lunch menu together, and discuss the vigilance required to self-monitor food products sold at athletic events or special student sales, foods brought for potlucks or classroom celebrations, and foods served on School-sponsored trips.

I do _____ do not _____ give consent for the School to notify others of my child's food allergy.