Dear Berean Parents**,**

One of the greatest privileges of serving as your school nurse is partnering with you to care for your children. My goal is to provide compassionate, timely care while also fostering independence, responsibility, and self-advocacy as students grow and learn within our school community.

Our general practice is to contact families when an injury or illness appears significant, when a student needs to be picked up due to illness, when symptoms interfere with participation in school activities, when medication is administered, or when a condition requires observation at home or follow-up with your healthcare provider. If there is ever an emergency or an immediate concern requiring your attention, you will receive a phone call right away.

Not every visit to the nurse's office requires parent notification. Many students stop by for very minor concerns such as a small scrape, an ice pack, a bandage, or other brief first-aid needs. In many cases, students receive simple care, feel well, and return to class without any interruption to their day. For our younger students, I may also send an email regarding bruises or minor injuries that they may not be able to explain clearly when they get home.

As part of a Christian classical education, we desire to help students grow not only academically, but also in wisdom, responsibility, and character. Learning when to ask for help, how to care for minor needs, and how to communicate those needs appropriately are valuable life skills that develop over time. The nurse's office provides a safe environment where students can practice these skills while knowing they are cared for.

Please know that if your child experiences an injury, illness, or health concern that requires your attention, monitoring at home, or medical follow-up, I will always communicate with you. Because the clinic is often very busy throughout the school day, communicating every visit would limit the time available to care for students who need immediate attention.

Thank you for your trust, partnership, and understanding as we work together to keep our students healthy, safe, and ready to learn. It is a blessing to care for your children each day.

With care and blessings,

Erica Sanders BSN RN
nurse@bereanchristianacademy.org

Berean Christian Academy

Medication Policy

MEDICATIONS:

All medication must be brought to the clinic by a parent/guardian. Medication will be secured in the clinic at all times.

ADMINISTERING MEDICATION:

School nurses and other school employees designated by the nurse are allowed to administer medication to students during school hours under the following conditions:

PRESCRIPTION MEDICINE:

Berean Christian Academy must receive a written request to administer medication from the parent, legal guardian or other person having legal control of the student. Medication must be prescribed by a medical professional licensed to practice in the United States. Appropriate form will be provided by the school nurse. An annual Emergency Action Plan is required from physicians for all emergency medications (insulin, inhaler, EpiPen, Auvi-Q, glucagon, etc.).

Prescription medication must be in the original container properly labeled with the child's name, name of medicine and directions for time and dosage.

Berean Christian Academy employees will not be required to administer any medication that exceeds recommended dosages or administer any procedure that conflicts with standard medical practice, as described in recognized medical reference on these issues.

NON- PRESCRIPTION MEDICINE:

Non-prescription medication must be in the original, unopened container. Student's name and directions for time/dosage shall be provided by the parent/legal guardian at the time the request to administer the medication is made. Appropriate form will be provided by the school nurse. Substances such as vitamins, herbal preparations, holistic remedies, etc. will not be given during school hours unless prescribed and signed for by a Board Certified Physician. Parent/legal guardians are welcome to come to the school and administer these remedies themselves if they wish.

Berean Christian Academy may keep a supply of specific over-the-counter medications purchased by the school. These medications may be administered to students by the school nurse or other designated school employees, provided that written permission is given by the student's parent or legal guardian. The medication must be unexpired, in its original container, properly labeled, and administered according to the dosage instructions on the label.

TRANSPORTATION AND STORAGE OF MEDICATIONS:

All medication must be brought to the clinic by a parent, guardian or other responsible adult and shall be secured there at all times. For the safety and protection of all students, medication will not be sent home with students. Students will not be allowed to carry medications except for emergency medications such as insulin, inhalers, epi-pens, or seizure rescue medication per their physician's signed recommendation.

PROFESSIONAL JUDGMENT :

In the event the school nurse, in the exercise of professional judgment, questions the administering of any particular medication as excessive or otherwise potentially harmful to the student, the nurse will cease to administer the medication and notify the parents and the physician. The nurse will consult with the Head of School and others as appropriate.

Updated 2/27/23

Berean Christian Academy

Administration of Medication (15+ Days)

Name (First/Last): _____ **Grade** (Grammar/Logic/Rhetoric): _____ **DOB**: ____ /____ /____

Parents,

Your child may have an illness which requires medication for relief/cure but does not prevent him/her from attending class. When possible, such medication should be scheduled to be taken at home. However, according to Texas law, a medication may be dispensed to a student by school staff. To accommodate this, the following requirements must be met by a parent or legal guardian:

Parental Permit to Administer Prescription or Non-Prescription Medication at School (15+ Days)

1. All prescription drugs and sample drugs dispensed through a physician's office must be in their original pharmacy container or packaging and labeled by the pharmacist or physician. The label must include:
   A. The student's name
   B. The physician's name
   C. The name and strength of the drug
   D. Amount of the drug to be given
   E. Frequency of administration
   F. Date prescription was filled

2. All non-prescription drugs must be in their original container. This written request for administration of these over the counter drugs, made by parent, legal guardian, or physician, must contain the following information:
   A. The student's name
   B. The name and strength of the drug
   C. Amount of the drug to be given
   D. Scheduled hours when the drug is to be given
   E. Reason drug is to be given
   F. Date
   G. Parent / Guardian Signature

3. All prescription and non-prescription drugs to be administered or kept at school for greater than 15 days must be accompanied by a written request signed and dated by the prescribing physician and the student's parent/guardian making the request.

4. Medications prescribed or requested to be given (3) times a day or less are not to be given at school unless a specific time (during school hours) is prescribed by a physician or if the school nurse determines that a special needs exists for a specific student.

5. There will be no more than one medication per container.

6. All medications will be stored and dispensed in the school clinic. Exceptions must be approved by school nurse and Head of School.

7. Students may not be in possession of prescription or non-prescription medications during school hours or at school-related activities, on or off campus. Exceptions must be approved in advance by the school nurse.

8. Natural and/or homeopathic products that are not FDA approved will not be dispensed by school nurse or school staff unless prescribed and signed for by a Board Certified Physician.

9. In accordance with the *Standards of Nursing Practice, Rule 217:11*, the school nurse has the responsibility and authority to clarify any medication order with appropriate licensed practitioner and/or refuse to administer medication that, in the nurse's judgement, is not in the best interest of the student.

10. It is procedure to return or destroy any unused medication a student has been taking at school once it has been discontinued or at the end of the school year. It is preferred that a parent/guardian retrieve the unused or request that it be destroyed. No controlled substances can be sent home with the student.

Medication #1: [ ] Prescription [ ] Non-Prescription **Name of Medication**: _____

Date To Begin Medication: ____ /____ /____ **Date To End Medication**: ____ /____ /____ **Time to Be Given**: _____

Amount to Be Given: _____ **Amount Provided to BCA:** _____

Reason for Medication: _____

Medication Form: [ ] Tablet [ ] Capsule [ ] Liquid [ ] Inhalant [ ] Other _____

[ ] **This is an emergency medication to remain with student** [ ] In Classroom [ ] With Student [ ] Other _____

Physician Name (First/Last): _____ **Physician Signature**: _____ **Date**: ____ /____ /____

FOR ADMINISTRATIVE USE ONLY

Person Picking Up Medication (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

Medication Disposal Witness (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

School Nurse (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

Medication #2: [ ] Prescription [ ] Non-Prescription **Name of Medication**: _____

Date To Begin Medication: ____ /____ /____ **Date To End Medication**: ____ /____ /____ **Time to Be Given**: _____

Amount to Be Given: _____ **Amount Provided to BCA:** _____

Reason for Medication: _____

Medication Form: [ ] Tablet [ ] Capsule [ ] Liquid [ ] Inhalant [ ] Other _____

[ ] **This is an emergency medication to remain with student** [ ] In Classroom [ ] With Student [ ] Other _____

Physician Name (First/Last): _____ **Physician Signature**: _____ **Date**: ____ /____ /____

FOR ADMINISTRATIVE USE ONLY

Person Picking Up Medication (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

Medication Disposal Witness (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

School Nurse (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

Medication #3: [ ] Prescription [ ] Non-Prescription **Name of Medication**: _____

Date To Begin Medication: ____ /____ /____ **Date To End Medication**: ____ /____ /____ **Time to Be Given**: _____

Amount to Be Given: _____ **Amount Provided to BCA:** _____

Reason for Medication: _____

Medication Form: [ ] Tablet [ ] Capsule [ ] Liquid [ ] Inhalant [ ] Other _____

[ ] **This is an emergency medication to remain with student** [ ] In Classroom [ ] With Student [ ] Other _____

Physician Name (First/Last): _____ **Physician Signature**: _____ **Date**: ____ /____ /____

FOR ADMINISTRATIVE USE ONLY

Person Picking Up Medication (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

Medication Disposal Witness (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

School Nurse (Print)**:** _____ **Signature:** _____ **Date**: ____ /____ /____

Parent / Guardian Name (First/Last): _____ **Signature**: _____ **Date**: ____ /____ /____

Updated 3/20/23

Berean Christian Academy

Asthma Action Plan

Name (First/Last): _____ **Grade** (Grammar/Logic/Rhetoric): _____ **DOB**: ____ /____ /____

MEDICATIONS/TREATMENT

Daily Medication: _____
(include dose, time, and route)

Needed for Exercise:

[ ] ____ puffs of MDI before exercise for ____ days with written parent consent (updated order from HCP required beyond above specified days)

Quick Relief Medication:

[ ] ____ puffs of _____ (MDI)

Q _____ hours as needed for below symptoms:

[ ] Coughing [ ] Chest Tightness

[ ] Retractions / Nasal flaring [ ] Wheezing

[ ] SpO2 ≤ ____ %

[ ] Repeat ____ times ____ minutes apart for persistent symptoms

[ ] Other: _____

_____
(include dose, time, and route)

CALL EMS IF:

[X] Person becomes unresponsive / unconscious

[X] Lips or fingernails appear blue

[X] Person is struggling to breath (breathing hard or fast)

[X] Can't speak due to difficulty breathing

[ ] SpO2 ≤ ____ %

[ ] Other: _____

_____

SELF-ADMINISTRATION

To be completed by healthcare provider (HCP) only

I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend:

[ ] Allowing student self-transport/administration of his/her quick relief MDI for the current school year. During my assessment the student verbalized the purpose of the medication, the time/ circumstance to administer, and when to seek help from school staff.

[ ] Restricting permission to self-transport/administer his/her quick relief MDI and reevaluating permission at a later date.

[ ] Other: _____

_____

_____

_____

ASTHMA FIRST AID

- Stay Calm and contact the school nurse
- Escort person to nurse's office if able to walk
- Activate this Emergency Action Plan
- Ensure upright positioning (to expand lung capacity)
- Administer medication as prescribed
- Remain with student

HCP Name: _____ **Signature**: _____ **Phone**: _____ **Date**: ____ /____ /____

I agree with the recommendations of my child's HCP and authorize BCA staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate BCA staff for the current school year.

Parent Name: _____ **Signature**: _____ **Phone**: _____ **Date**: ____ /____ /____

Updated 3/13/23

Berean Christian Academy

Allergy and Anaphylaxis Action Plan

Name (First/Last): _____ **Grade** (Grammar/Logic/Rhetoric): _____ **DOB**: ____ /____ /____

Allergic To: _____ **Asthma**? [Y/N] **If Yes, At Risk of Severe Reaction**? [Y/N]

MEDICATIONS

Epinephrine brand: _____

Epinephrine dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

[ ] If checked, **give epinephrine immediately** if the allergen was definitely eaten, even if no symptoms are noted, and then call 911

Antihistamine brand or generic: _____

Oral antihistamine dose: _____

Other notes: _____

_____

SELF-ADMINISTRATION

To be completed by healthcare provider (HCP) only

I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend:

[ ] Allowing student self-transport/administration of the epinephrine for the current school year. During my assessment the student verbalized the purpose of the medication, the time/circumstance to administer, and when to seek help from school staff.

[ ] Restricting permission to self-transport/administer epinephrine and reevaluating permission at a later date.

[ ] Other: _____

_____

Symptom Severity: (Mild / Severe?)	**BCA staff will administer medication(s) as prescribed, contact 911 in the event of epinephrine administration, and notify parents/ guardians of action plan initiation (mild or severe response)**	**HCP Treatment Plan:**
Nose:	Itchy/runny, sneezing	[ ] Epinephrine + 911 [ ] Antihistamine
Mouth:	Itchy/tingling	[ ] Epinephrine + 911 [ ] Antihistamine
Mouth:	Significant swelling of tongue and/or lips	[ ] Epinephrine + 911 [ ] Antihistamine
Gut:	Nausea/mild discomfort	[ ] Epinephrine + 911 [ ] Antihistamine
Gut:	Repetitive vomiting, severe diarrhea, severe discomfort	[ ] Epinephrine + 911 [ ] Antihistamine
Throat:	Tight/hoarse, trouble breathing/swallowing, or swelling	[ ] Epinephrine + 911 [ ] Antihistamine
Heart:	Pale, blue, faint, weak pulse, dizzy	[ ] Epinephrine + 911 [ ] Antihistamine
Lungs:	Short of breath, wheezing, repetitive cough	[ ] Epinephrine + 911 [ ] Antihistamine
Skin:	Few hives, mild itch	[ ] Epinephrine + 911 [ ] Antihistamine
Skin:	Many hives over body, widespread redness	[ ] Epinephrine + 911 [ ] Antihistamine
Other:		[ ] Epinephrine + 911 [ ] Antihistamine

[ ] Repeat epinephrine for symptoms lasting longer than _____ minutes after first dose

HCP Name: _____ **Signature**: _____ **Phone**: _____ **Date**: ____ /____ /____

I agree with the recommendations of my child's HCP and authorize BCA staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate BCA staff for the current school year.

Parent Name: _____ **Signature**: _____ **Phone**: _____ **Date**: ____ /____ /____

OTC Medication Permission Form 2026-2027

Berean Christian Academy

Student Name: _____ **DOB**: _____ **Grade**: _____

By initialing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury.

_____ Acetaminophen (Tylenol)

_____ Ibuprofen (Advil or Motrin)

_____ Benadryl

_____ Hydrocortisone Cream 1% (over the counter strength)

_____ Neosporin Ointment

_____ Sting Relief (topical that contains lidocaine and alcohol for ant/insect bite relief)

_____ Cough Drops

School personnel who administer medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously taken the medication(s) listed above with no known adverse reaction.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____