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.

Medication Permission Form

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
_____ 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: _____

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**: ____ /____ /____

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 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.

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**: ____ /____ /____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2020

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/ games/matches.