



# Special Care Plan



## FOR ALLERGIC REACTIONS AND REQUEST FOR ADMINISTRATION OF MEDICATION

Student: \_\_\_\_\_ Class: \_\_\_\_\_

### Parent/Legal Guardian's Request and Authorization:

I, the undersigned, request and authorize the personnel of Montessori of Maui, Inc to administer medication as prescribed by my child's physician. I also request and give my permission to Montessori of Maui, Inc. to release pertinent information to my child's physician. I understand that a new request must be completed should there be any change to the medication order.

\_\_\_\_\_  
Parent/Legal Guardian Name

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

☐ I have read the Request for Administration Medication instructions on the back of this form.

### Physician's Request and Authorization:

ALLERGEN(S) ☐ Food ☐ Insect ☐ Other: \_\_\_\_\_

☐ Asthmatic (increases risk for severe reaction)

Program Modifications: \_\_\_\_\_

MEDICATION(S):

Antihistamine Ordered ☐ Yes ☐ No Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Epinephrine Ordered: ☐ Yes ☐ No \*\*\*IF EPIPEN IS ADMINISTERED CALL 911\*\*\*

Special instructions: \_\_\_\_\_

#### SYMPTOMS:

- ☐ If exposed to allergen, or allergen ingested, but no symptoms
- ☐ MOUTH Itching & swelling of lips, tongue or mouth.....
- ☐ THROAT Itching, tightness in throat, hoarseness, cough.....
- ☐ SKIN Hives, itchy rash, swelling of face and extremities.....
- ☐ STOMACH Nausea, abdominal cramps, vomiting, diarrhea.....
- ☐ LUNG Shortness of breath, repetitive cough, wheezing.....
- ☐ HEART Faint, pale, weak pulse, passing out.....
- ☐ OTHER \_\_\_\_\_

#### TREATMENT AND MEDICATION:

- ☐ Antihistamine ☐ Epinephrine
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Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_



# ***Special Care Plan***



## **Request for Administration of Medication Instructions:**

- Medications for daily, routine and/or life threatening conditions may be administered during the school day. Medications should be given at home as much as possible unless there are reasons, provided by the physician, why they must be given during the school day.
- All medications must be prescribed by a physician. Medications listed in form must match the labeled medication stored at school.
- The Special Care Plan Form and Request for Administration of Medication must be completed and signed by a physician.
- Medication must be in the original container; labeled with the child's name and physician's dosage instructions.
- Proper paperwork and medications must be turned into the Main Office before the child can attend school, an overnight or Off-Island Field Trip.
- If there are any changes in medication or dosage, the Main Office must be notified and a new form must be completed and signed by a physician.
- Single dose antihistamine is the preferred medication when an antihistamine is required.
- When an Epi-Pen is administered, parent/guardian and 911 will be notified. The school will defer to Emergency Medical Service (EMS) personnel with respect as to whether transport to a medical facility is needed. If EMS personnel determines that transport to a medical facility is not needed, the parent/guardian will be informed to pick up the student.

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## **FOR MONTESSORI SCHOOL OFFICE USE ONLY:**

### **Medication Stored:**

☐ In Main Office ☐ In Classroom ☐ With Teacher(s) or Chaperone(s)

Class: \_\_\_\_\_ Teacher: \_\_\_\_\_

### **Staff Notified:**

☐ Administration ☐ Teacher(s) ☐ Resource Teacher(s) ☐ Aftercare Attendant(s)  
☐ Added to RenWeb

### **Copies of Form:**

☐ With Medication ☐ In Student File ☐ Given to Parent

Administrative Signature: \_\_\_\_\_ Date: \_\_\_\_\_