ST. PETER LUTHERAN SCHOOL

Incidental Medical Services (IMS) Plan

It is the goal of the St. Peter Preschool to be as inclusive as possible, including providing care for children with various ongoing medical conditions. The following plan outlines our procedures for the three conditions we currently accommodate:

1. We can accommodate children with anaphylaxis (severe, potentially life threatening allergies), asthma (chronic lung disease that impairs breathing), seizure disorders (febrile seizures), and sleep/breathing disorders (sleep apnea). Other medications maybe accepted and trained for on a case by case basis.

2. Personal plan of care procedures provided by a doctor or parent will be kept for each child with one of the above conditions.

3. EpiPens, inhalers, nebulizers, and breathing monitors will be labeled by a pharmacist and in the pharmaceutical container. The label will state: Student's name, date, name of medication, dosage, time to be given, special instructions, and physicians name. Once on campus it will be kept in the medical box in each room/site.

4. At least one staff member is on campus that is certified in pediatric first aid and CPR. In addition, the permission for inhaler/nebulizer use is specific to certain trained staff who are trained in their use by the parent/guardian.

5. Parents/authorized guardians are required to sign a written consent to administer inhaler/nebulizer treatments in addition to the permission to administer other medications. Also, the child's physician must provide a signed form.

6. We ensure that proper safety precautions are met, including the wearing of gloves to reduce exposure to bodily fluids, proper hand cleaning following glove removal, and safe disposal of all contaminated materials.

7. Medication/appliances will be taken on field trips or other off site activities.

8. Medication/appliances will be taken on drills or in case of a real emergency/disaster.

9. Routine and predicted treatment will be logged on the Parent Consent Form (LIC 9221).

10. Medical incidents outside of routine and predicted treatment will also be recorded and kept in the office). Parents will also be notified by phone.

11. 911 will be called for emergency medical incidents and/or for symptoms or reactions outside those addressed in the scope of the parent/written documentation. Emergency services may also be contacted for any medical situation which is outside the comfort or knowledge of the staff present on any given day.

12. Serious incidents and any change in this plan will be reported to the Department of Social Service licensing office and an Unusual Incident Report (LIC624) will be filed.

13. The Center reserves the right to decline or terminate enrollment of a child with any of the above conditions if we believe the condition/treatment needs are beyond the scope of our staff's training or ability to perform in the context of a group setting. In addition, enrollment may be suspended or terminated if communication with the parent does not support full understanding of treatment needs, or if parents fail to provide medication/supplies, instructions, and any required documentation.

ST. PETER LUTHERAN SCHOOL

Incidental Medical Services (IMS) Plan Continued

Child's name: _____ DOB: ____/____/____

Teacher (s): _____ Room: _____

Type of Incidental Medical Service (IMS) Plan:

o Anaphylaxis o Febrile Seizures o Sleep Apnea o Asthma o Other _____

Type of Medication:

o EpiPen Jr. Expiration date: ____/____/_____

o Inhaler Expiration date: ____/____/_____

o Nebulizer Expiration date: ____/____/_____

o Other (please specify): _____

Expiration date: ____/____/_____

Location of Medication: _____

Person(s) listed below are authorized and trained to administer medication by

the Parent/Guardian Name_____ Date: _____:

1.) _____ 4.)_____
2.) _____ 5.)_____
3.) _____ 6.) _____

----------St. Peter Office Personnel Only ----------

CHECKLIST:
o Action Plan and Parent Request/Physicians Statement complete and on file
o Parent Consent for Administration of Medication and Medication Chart (LIC 9221)
o Medication/Verification of prescription label and in pharmaceutical container then placed in Emergency Backpack/ Lockbox
o If Applicable LIC 9166 Nebulizer form
Form completed by:
(staff member's printed name): _____
Staff member's signature: _____
Date form was completed: ____/____/_____

ST. PETER LUTHERAN SCHOOL
EST. 1904

Incidental Medical Services (IMS) Plan Continued

Medication in Schools Parent Request/Physician's Statement

Name of student _____ Date: _____

Name of teacher _____ Grade: _____

Medication may be dispensed to students at school if the following information is completed and the parent/guardian agrees to following terms and conditions.

Name of medication _____ Dosage: _____

Time to be given: _____ Length of time to be given: _____

Special instructions: _____

I understand and agree to the following Please read and initial each point:

1. Staff members will be trained by the parent/guardian to give the medication to the student. _____
2. I, the parent/guardian, will bring the medication to the school personally and give it to a staff member and it will be placed in the emergency backpack/lockbox. _____
3. The medication will be labeled by a pharmacist and in the pharmaceutical container. The label will state: Student's name, expiration date, name of medication, dosage, time to be given, special instructions, Prescription #, and physician's name. _____
4. St. Peter Lutheran Church and School and its staff are not responsible for the side effects of the medication. In return for the school's assistance in administering the medication to my child, I hereby waive on my behalf, and on behalf of my child, the right to maintain any legal action for damages against the school and its staff for any adverse effect that the medication may have on my child. _____
5. I verify and understand that I have read the Incidental Medical Services Plan, completed the (IMS) form, LIC 9221 Parent consent form completed, and completed the Medication in Schools Parent/ Physicians Statement (this form) _____
6. Nebulizer Care Consent/ Verification LIC 9166 complete (If applicable) _____

Parent/Guardian Signature: _____ Date: _____

----------TO BE COMPLETED BY THE PHYSICIAN----------

Medication: _____ Dosage: _____

Indication for Medication: _____ Duration: _____

Special Instructions/Precaution: _____

Possible Side Effects: _____

Physician's Signature: _____ Physicians Stamp Here

Physicians Name: _____

Address: _____

Telephone: _____