Ridgefield Public Schools

Severe Allergy Emergency Health Care Plan

PARENT AND PHYSICIAN FORM

Student Name: _____ DOB: _____
Address: _____ Phone:_____
Mother's Name: _____ Phone:_____
Father's Name: _____ Phone:_____
Primary Physician: _____ Phone:_____
Hospital Choice: _____
1. Emergency Contact: _____
Relationship:_____ Phone:_____
2. Emergency Contact: _____
Relationship:_____ Phone:_____
3. Emergency Contact: _____
Relationship:_____ Phone:_____

Place Child's Photo Here

ALLERGY TO: _____
Asthmatic: ____ YES ____ NO ****High risk for severe reaction**

SIGNS OF ALLERGIC REACTION INCLUDE
(Circle those symptoms that may apply to the student.)

SYSTEMS	**SYMPTOMS**
MOUTH	itching & swelling of lips, tongue, or mouth
THROAT*	itching &/or sense of tightness in the throat, hoarseness & hacking cough
SKIN	hives, itchy rash, &/or swelling about the face or extremities
GUT	nausea, abdominal cramps, vomiting, &/or diarrhea
LUNG*	shortness of breath, repetitive coughing, &/or wheezing
HEART*	"thready" pulse, "passing out"

*****The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening condition. *****

ACTION:
If contact with _____is suspected,
(Allergen)

1. **Give** _____
2. **Give** _____
3. **Give** _____
4. **Call EMS** _____
5. **Call** _____
6. **Call** _____

Permission to share information with school personnel (where applicable):
Parent/Guardian____ Principal____ Guidance Dept____ Teachers____ Student____
School Nurse ____ Lunch/Recess Paras ____ Cafeteria Staff ____ Bus Company____
Allergen Free Table in Cafeteria ____ YES ____ NO

***** DO NOT HESITATE TO ADMINSTER MEDICATION OR CALL EMS EVEN IF PARENTS OR MD CANNOT BE REACHED *****

_____ _____ _____ _____
Parent Signature DATE Physician Signature Date

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Student Name: _____ Grade/Teacher:_____

Does your child take/use any medication/equipment/supplies for this medical condition at home? (YES / NO)(Circle one)

If yes, please list all medications/equipment/supplies used at home:

_____

_____

_____

_____

_____

In the event your child cannot get home due to an emergency, do you wish a supply of the listed medications/equipment/supplies be kept at school? (YES / NO) (Circle One)

(Parent to provide equipment/supplies or medication and medication authorization forms for each medication)

_____ _____
Signature of Parent/Guardian Date

Nurse to complete:

Medications/Equipment/Supplies received (List):

_____

_____

_____

_____

_____

_____ _____
Signature of Nurse Date

RIDGEFIELD PUBLIC SCHOOLS

School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name/ Strength _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work #: _____

I DO / DO NOT (circle one) wish the medication BROUGHT on field trips

I DO / DO NOT wish medication ADMINISTERED on shortened days _____ _____
Signature Date

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication (inhalers, EpiPens or other medications approved by the School Medical Advisor and Head Nurse) may be authorized for middle and high school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self administration: ☐ Yes ☐ No _____ _____
Signature Date

Parent/Guardian authorization for self administration: ☐ Yes ☐ No _____ _____
Signature Date

School nurse approval for self administration: ☐ Yes ☐ No _____ _____
Signature Date

Received by _____ Date of Receipt/Form_____ Date of Receipt/Medication _____

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