

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: _____



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

MOUTH

THROAT*

SKIN

GUT

LUNG*

HEART*

SYMPTOMS

itching & swelling of lips, tongue, or mouth

itching &/or sense of tightness in the throat, hoarseness & hacking cough

hives, itchy rash, &/or swelling about the face or extremities

nausea, abdominal cramps, vomiting, &/or diarrhea

shortness of breath, repetitive coughing, &/or wheezing

"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 ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR MD CANNOT BE REACHED *****

Parent Signature

DATE

Physician Signature

Date

Ridgefield Public Schools

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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

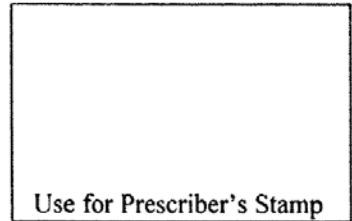
Prescriber's Name/Title: _____

(Type or print)

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____



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 _____