WILTON PUBLIC SCHOOLS

AUTHORIZATION OF EMERGENCY TREATMENT OF FOOD/INSECT ALLERGIES

Student's name_____Date of Birth_____Weight_____Student's Photo

Mother's name_____ Phone#_____Cell#_____

Father's name_____ Phone#_____Cell#_____

Physician's name_____ Phone#_____

ALLERGY TO:_____

Asthmatic: YES*_____ NO _____ *HIGH RISK FOR SEVERE REACTION

If student has multiple allergies and plan of action is different, PLEASE LIST ON A SEPARATE FORM !

SIGNS OF ALLERGIC REACTION INCLUDE

(Circle those symptoms that may apply to the student)

SYSTEMS	SYMPTOMS
Mouth	Itching and swelling of lips, tongue or mouth
Throat	Itching and/or sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, itchy rash and /or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting and/or diarrhea
Lungs	Shortness of breath, repetitive coughing and/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, (list in numerical order Plan of Action)

_____ Observe patient for symptoms of anaphylaxis**

_____ Administer epinephrine/epipen IM before symptoms occur: DOSE_____

_____ Administer epinephrine/epipen IM if symptoms occur: DOSE_____

_____ Administer diphenhydramine/Benadryl by mouth: DOSE_____

_____ Call 911 EMS AND TRANSPORT TO ER if EPINEPHRINE GIVEN. NOTE time of injection.

***Readminister Epinephrine in Ten (10) Minutes If Symptoms Persist.**

*****In the absence of a school nurse, trained qualified personnel will administer epinephrine before symptoms if ingestion of allergen is suspected.**

_____ _____

Physician's Signature **Date**

I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure safe administration of prescribed medication.

_____ _____

Parent Signature **Date**

SEE REVERSE SIDE FOR SELF ADMINISTRATION

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a verified chronic medical condition, self administration of emergency medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to Connecticut State Regulations, Section 10-212a-4, and in accordance with Board policy.

Please indicate:

_____Rescue Asthma Inhaler

_____Cartridge Injector for Medically Diagnosed Allergies

_____ Insulin by Insulin Pump or Injection

Prescriber's Authorization:

It is my opinion that _____has sufficient knowledge and understanding of his/her medication to warrant permission to carry and to self administer this medication during school hours, on a field trip, before and after school programs and athletic events.

_____ _____

Physician Signature Date

Parent/Guardian Authorization:

I give my son/daughter_____permission to self administer his/her medication during school hours, on a field trip, before and after school programs and athletic events.

_____ _____

Parent/Guardian Signature Date

School Nurse Review: Date_____

Comments:

Approved: _____ Date _____
Denied: _____ Date _____
Not Required: _____ Date _____

_____ _____

School Nurse Signature Date