FOOD / INSECT ALLERGY EMERGENCY PLAN OF CARE DURING SCHOOL

School _____ School Year _____

STUDENT INFORMATION		
	Student Name:	DOB:
	Home / Cell Phone:	Grade:
	Life-Threatening Allergies:	History of Asthma? □ No □ Yes (Asthma may indicate an increased risk of sever reaction)
		Severe Anaphylactic Reaction? □ No □ Yes Dates of Anaphylactic Reaction: _____ ☐ If checked YES, give Epinephrine immediately if allergen was likely eaten, at onset of any symptoms, and follow the protocol below.

TREATMENT PLAN		
	ANY SEVERE SYMPTOMS (Anaphylaxis) AFTER SUSPECTED OR KNOWN INGESTION: / CONTACT ONE OR MORE OF THE FOLLOWING: **LUNG:** Short of breath, chest tightness, wheeze, repetitive cough **HEART:** Pale, blue, faint, weak pulse, dizzy /confused **THROAT:** Tight, hoarse, trouble breathing / swallowing, drooling **MOUTH:** Obstructive swelling (tongue or lips) OR COMBINATION OF SYMPTOMS FROM *DIFERENT BODY AREAS*: **SKIN:** Hives, itchy rashes, swelling (e.g. eyes, lips) **GUT:** Nausea, Vomiting, diarrhea, crampy pain	FOLLOW THIS PROTOCOL: 1. INJECT EPINEPHRINE IMMEDIATELY! 2. Call 911 3. Raise feet above the head, remain lying down and continue monitoring. 4. Give additional medications as ordered - Antihistamine - Bronchodilator/Albuterol if has asthma 5. Notify Parent/Guardian 6. Notify Prescribing Provider / PCP 7. When indicated, assist student to rise slowly
	ORAL ALLERGY SYNDROME OR MILD SYMPTOMS: **MOUTH:** Itchy mouth, lips, tongue and/or throat SKIN: Itching just around mouth GUT: Mild Nausea, Vomiting, diarrhea, crampy pain	1. GIVE ANTIHISTAMINE (swish and swallow if liquid) 2. Monitor student as indicate; notify healthcare provider and parent as indicated. 3. If progresses to symptoms of anaphylaxis, USE EPINEPHRINE (as stated above)

_____ _____
Physician Name / Telephone Physician's Signature

_____ _____
Guardian Name / Telephone Guardian Signature

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

✦ **Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____**

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

✦ **Prescriber's Signature** _____ Date _____/_____/_____

Parent/Guardian Authorization:

- ✓ I request that medication be administered to my child/student as described and directed above
- ✓ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- ✓ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

✦ **Parent/Guardian Signature**_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____ Town_____ State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐YES ☐NO _____ _____
Signature Date

Parent/Guardian authorization for self-administration: ☐YES ☐NO _____ _____
Signature Date

STAFF approval for self-administration: ☐YES ☐NO _____ _____
Signature Date

✦ Today's Date _____ Printed Name of **ROSCCO STAFF** Receiving Written Authorization_____

Date _____ Printed Name of **Site Coordinator** Receiving Medication_____

✦ _____ **Site Coordinator Signature**

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Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

✦ Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

✦ Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

- ✓ I request that medication be administered to my child/student as described and directed above
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- ✓ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

✦ Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

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Signature Date

STAFF approval for self-administration: ☐YES ☐NO _____ _____
Signature Date

✦ Today's Date _____ Printed Name of **ROSCCO STAFF** Receiving Written Authorization_____

Date _____ Printed Name of **Site Coordinator** Receiving Medication_____

✦ _____ **Site Coordinator Signature**