

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM MEDICATION

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL
FOR STUDENT WITH A KNOWN FOOD ALLERGY**

Name of Student _____ Date of Birth _____

Specific Food Allergen _____

To order one of the food allergy medication protocols below for this student, please **check off and complete** the appropriate section and sign.

For a child with known food allergy and a history of a **life threatening allergic reaction*** to the food: If child thinks he ate or knowingly ate the food: Administer epinephrine immediately.

Check one: Epipen (epinephrine 0.3mg) IM or SC Epipen, Jr. (epinephrine 0.15mg) IM or SC
_____ x 1 in 10 minutes as needed for symptoms of allergic reaction.

Prescriber: Please prescribe two Epipens/Epipen, Jr.'s for child to have in school if repeat dose is ordered.

Student may self-administer. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication. Self-administration of medication means that the student will carry and administer his/her medication without assistance. Self-administration must be authorized by the prescriber and parent/guardian and approved by the School Nurse who will periodically supervise the student as needed.

Side effects/plan for management: _____

**Life threatening allergic reaction - a reaction involving the mouth, throat, respiratory, cardiovascular, or gastrointestinal system or involving the skin and a feeling of apprehension, impending doom, or weakness.*

Duration of Order(s): from _____ to _____ (dates)
_____ M.D./D.O./D.D.S./A.PRN./P.A.

Date: _____ Address and Phone _____

For a child with a history of **non-life threatening**** allergic reaction to a food: If child thinks he ate the food, or knowingly ate the food:

Observe child for at least two hours for any signs of a reaction.

Administer epinephrine if any of these symptoms occur: Respiratory difficulty, cough, repetitive sneezing, dizziness, faintness, signs of shock, tightness, itching of throat, difficulty swallowing, nausea, vomiting, cramps, diarrhea, swelling of lips, mouth, tongue, throat, hives or rash combined with apprehension, weakness, or sense of impending doom.

Check one: Epipen (epinephrine 0.3mg) IM or SC Epipen, Jr. (epinephrine 0.15mg) IM or SC
_____ x 1 in 15-20 minutes as needed for symptoms of allergic reaction.

Prescriber: Please prescribe two Epipens/Epipen, Jr.'s for child to have in school if repeat dose is ordered.

Student may self-administer. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication. Self-administration means that the student will carry and administer his/her medication without assistance. Self administration must be authorized by the prescriber and parent/guardian and approved by the School Nurse. The nurse will periodically supervise the student as needed.

***Non-life threatening allergic reaction - a reaction involving only the skin or only a feeling of apprehension, of impending doom, or weakness.*

Duration of Order(s): from _____ to _____ (dates)
_____ M.D./D.O./D.D.S./A.PRN./P.A.

Date: _____ Address and Phone _____

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

**AUTHORIZATION OF PARENT OR GUARDIAN
FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

Connecticut State Law requires the written medication order of a physician, dentist, or an Advanced Practice Registered Nurse or Physician's Assistant licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 45-day supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student _____ **Date of Birth** _____

School _____ **Grade** _____

Medication _____

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

Self-administration of medication means that the student will carry and administer his/her medication without assistance. Self-administration must be authorized by the prescriber and parent/guardian and approved by the School Nurse. The nurse will periodically supervise the student as needed.

Student may self-administer the above medication: Yes No

For daily medication - Plan for early dismissal days (check one):

Give medication in school as usual

Do not give medication in school

Plan for delayed opening: On days that opening of school is delayed, the parent or guardian must notify the school nurse if any change in the student's medication schedule is needed.

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of that medication order in school.

I authorize that this medication be destroyed if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

DATE

SIGNATURE OF PARENT/GUARDIAN

PRINT NAME OF PARENT/GUARDIAN

PHONE