



476 Skiff Mountain Road • Kent, CT 06757-3001 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

Dear Parent/Guardian,

Thank you for taking the time to fill out all health forms. Your student's forms should be received at least one month prior to registration. Students cannot be on campus without the required forms.

Safety is our highest priority and we take it very seriously. It is imperative that we adhere to the following safety protocol and Connecticut state law: Please note that anytime there is a medication, vitamin or supplement change, you or your child will need to bring/provide a signed doctor's order to school with him/her for **ANY** of the following reasons:

1. If a new medication is added,
2. If a medication he/she has been taking is discontinued,
3. If the strength or dosage of a medication changes. i.e.: 20 mg daily changes to 30 mg,
4. If he/she is ill and begins taking an antibiotic while home and will need to continue taking it once back at school. (this includes eye/ear drops),
5. If you or the doctor decides to begin daily over the counter vitamins/supplements, sleep aids or laxatives,
6. If he/she is injured and cannot participate in sports or an activity upon return.

If your child has any significant diagnostic testing while at home– i.e.: lab work, x-rays, MRI, vaccinations– please be sure to provide the Health Services Office with a copy so that it may become part of your child's Marvelwood medical record.

The Marvelwood School Health Services team would like to thank you in advance for adherence to the above protocols. Please know that we are here to be of assistance to you and your child. Do not hesitate to contact us with any questions or concerns. Thank you.

Jayne Janecek, LPN, P'06, '10, '13, '16
Director of Health Services
The Marvelwood School
476 Skiff Mountain Road
Kent, CT 06757
860-927-0047 Ext. 1021
860-927-5321
Fax: 860-927-2133

The following forms **MUST** be received by the Health Office at least one month prior to the student's arrival on campus. Forms 1-7 should be filled out by a parent or guardian; forms 8-11 to be filled out by a Physician.

All students must have an account set up with Kent Apothecary prior to the start of school regardless of whether or not they take regular medication. Please review and complete the separate Kent Pharmacy Registration Packet. This packet should be returned directly to Kent Station Pharmacy.

- 1. Emergency Consent – REQUIRED**
To be completed and signed by parent or guardian.
- 2. Personal History – REQUIRED**
To be completed by parent or guardian.
- 3. Testing Consent – REQUIRED**
To be completed and signed by parent/guardian and student.
- 4. Permission to Transport Medication**
To be completed and signed by parent or guardian. Only required if student takes medication and parent/guardian wants student to be able to carry medication to/from school.
- 5. Student Information for School Physician – REQUIRED**
To be completed and signed by parent or guardian.
- 6. Health Insurance Information – REQUIRED**
Please read and provide information as requested.
- 7. Influenza Vaccination Consent – HIGHLY RECOMMENDED**
To be completed and signed by parent or guardian.
- 8. Physical Examination – REQUIRED**
To be completed by Physician each school year. If physical exam is out of date or not provided your child will be sent to our school doctor to have one and the fee will be billed home.
- 9. Immunization History – REQUIRED**
Needs to be filled out and completed by a physician initially for 1st year students and updated yearly only if vaccines are given by a physician at home.
- 10. Medication Authorization**
Only required if student takes prescription medication.
- 11. Allergy Requiring EpiPen**
Only required if student has a life-threatening allergy that requires an EpiPen.

*If you have any questions please contact the staff at nurses@marvelwood.org.
Completed forms should be faxed, emailed, or mailed to:*

Health Office
Marvelwood School
476 Skiff Mountain Road, Kent, CT 06757
(860) 927-5321 • (860) 927-2133 (fax)
nurses@marvelwood.org

STUDENT'S NAME (Last, First, MI): _____ Grade _____

Student's Cell Phone: _____ Sex (M/F) _____ Date of Birth (Month/Day/Year) ____/____/____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Country _____

AUTHORIZATION FOR CARE AND TREATMENT – Self-authorization by a student is not permitted.

I hereby authorize The Marvelwood School to administer medical care and treatment, including medication and immunizations, and routine diagnostic tests for injuries and illness my child may incur while at school. I agree to notify The Marvelwood School of any conditions arising when my child is not at school. I authorize the release of information and medical records to facilitate the medical, surgical or psychiatric care of my child. In the event of an emergency, illness or injury where there is an urgent need for treatment or which may affect the recovery of my child if not promptly treated and I am unable to be contacted, I authorize the school or its representative to assume the responsibility for the care and treatment of my child which may include hospitalization, diagnostic tests and/or surgery.

Parent or Guardian Signature: _____ Date: _____

Please print name: _____

PARENT/GUARDIAN INFORMATION

Student Resides with (Please circle one): Both Parents Father Mother Other Relationship _____

Parent/Guardian #1 _____ Relationship _____ *Please circle preferred method of contact : home phone, work phone, cell phone, e-mail.*

Telephone: (H) _____ (W) _____ (Cell) _____

E-mail: (H) _____ (W) _____

Parent/Guardian #2 _____ Relationship _____ *Please circle preferred method of contact : home phone, work phone, cell phone, e-mail.*

Telephone: (H) _____ (W) _____ (Cell) _____

E-mail: (H) _____ (W) _____

Alternate Emergency Contact _____ Relationship _____ *Please circle preferred method of contact : home phone, work phone, cell phone, e-mail.*

Telephone: (H) _____ (W) _____ (Cell) _____

E-mail: (H) _____ (W) _____

INSURANCE INFORMATION – Please attach a clear copy, front and back, of the student's insurance card.

Medical insurance is required for all students.

The Marvelwood School is not responsible for payment of bills for health services.

EMERGENCY CARE INFORMATION:

Date of last TD Booster: _____ Significant Allergies (Drug/Food/Insect) _____

476 Skiff Mountain Road • Kent, CT 06757-3001 • Tel: 860-927-5321 • Fax: 860-927-2133 • Email: nurses@marvelwood.org

TO THE STUDENT/PARENT: This information is strictly for the use of the Health Services Office in providing care. It will be treated confidentially. Please inform Health Services if there is any change of condition between completion of this form and the start of school. Please complete Personal History in full. Comment on all "YES" answers in the space provided or attach a separate sheet.

STUDENT'S NAME _____ Date of Birth (Month/Day/Year) ____/____/____

Do you have or have you ever had...?	YES	NO
ADHD/Learning Disability		
Alcohol or Other Drug Use		
Anemia/Blood Disorder		
Anxiety		
Asthma/Wheezing		
Back Problems		
Cancer/Tumor		
Cardiac Issues/Heart Disease/Heart Murmur		
Chest Pain/Shortness of Breath		
Counseling/Psychotherapy		
Dental Problems		
Depression		
Diabetes		
Headaches/Migraines		
Head Injury/Concussion		
Insomnia		
Meningitis		
Psycho-educational testing		
Psychological evaluation		
Recent Weight Change/Eating Concerns		
Seizures		
Tobacco Use		
Other Illness		

Personal History – Please complete in full.

Medication & Dosage <i>(regular or as needed)</i>	Therapeutic Program
	Hospitalizations (date & diagnosis)
Allergies to Medication	
Reaction	
Allergies to Food	Surgery (date & diagnosis)
Reaction	
Other Allergies	
What treatment is needed?	Significant Illness (date & diagnosis)

Please attach detailed information from physician

Family History – Biological (if available)

Relationship	Age	State of Health	Medical Issue(s)
Father			
Mother			
Brother(s)			
Sister(s)			

Women Menstruation: Age of Onset _____
 Menstrual Problems _____
 Birth Control Method _____

Are the student's parents separated/divorced? Yes _____ No _____
 When? _____
 Who has custody? _____

I declare that the information provided above is true and complete and that I have not withheld any information.

Signed: _____ Date: _____

By signing this paper, my child and I agree that Marvelwood School can direct that my child be tested for the presence of drugs/alcohol in his/her system. We further agree that such tests can be random or regular, with or without cause. For any positive results, we also give permission for confirmation testing to be carried out by Quest Diagnostics to determine drug level.

You will be notified by the Dean of Students as soon as possible that the testing has taken place. In addition, you will be notified of the testing results in a timely fashion by the Dean of Students. Parents are responsible for laboratory fees associated with confirmation testing and any testing done on campus.

Parent name (print): _____

▶ Parent signature: _____ Date: _____

Student name (print): _____

Student signature: _____ Date: _____

Dear Marvelwood Families,

Domestic students are not permitted to transport large quantities of medications to or from school.

1. Parents/guardians may pick up medications in person from a nurse in the Health Services Office.
2. Kent Station Pharmacy will ship a sufficient supply of medications home via courier. Shipping charges will be billed home.
3. Families may work with their prescribing doctor(s) and home pharmacy to ensure that they have enough medications on hand at home during the break, making pick-up or shipment unnecessary. Most insurance companies will allow for vacation overrides within the policy.

Students traveling home over multiple days will be given travel doses. Some exemptions will arise. In these cases, we will work directly with families to determine the safest logical practice.

The Health Services Office makes every effort to ensure the safety of our students as well as the security of their medications. We will do everything we can to help families adjust to this change in policy. Please feel free to contact us with any questions or concerns. Thank you for your understanding and cooperation. Thank you.

Jayne Janecek, LPN, P'06, '10, '13, '16
Director of Health Services
The Marvelwood School
476 Skiff Mountain Road
Kent, CT 06757
860-927-0047 Ext. 1021
860-927-5321
Fax: 860-927-2133
Email: jayne.janecek@marvelwood.org

Permission to transport small quantity of medication for weekends/ college visits or a few days at home.

It is our policy that students are not to have any prescription, controlled, or over-the-counter medications, supplements or vitamins of any kind in their possession while on campus. The only exceptions to this policy are epipens, asthma inhalers and topical acne medications. Accordingly, students with permission to transport their own medication will either pick them up from the Health office or be given them to pack prior to departure on the day of travel, or the day before they travel. The day they return, please hand in any new medications or new medication orders to the nurse at the Health office.

In order to grant permission for your child to transport his/her medications to and from campus this school year, please sign and date the form below and e-mail or fax it to the Health Office. The signed form will remain in the Health Office files and is valid for the 2019-2020 school year.

This permission and privilege may be revoked by the school if the student does not comply with stated policies regarding transportation of medications. Students found mishandling or in possession of controlled or other medications while school is in session may be subject to disciplinary process.

I hereby request that my child _____ be permitted to transport his/her medications to and from campus during the 2019-2020 school year.



SIGNATURE OF PARENT/GUARDIAN

DATE

Permission will not be accepted via telephone or email without the accompanying form.

Return original or legible faxed or emailed copy to:

The Marvelwood School
Health Services
476 Skiff Mountain Road
Kent, CT 06757-3001
Fax: (860) 927-2133
Email: nurses@marvelwood.org

The following information will be kept on file by our school physician, Dr. Roman Alder, in the event that your child needs medical care while at school.

STUDENT'S NAME _____ Sex M ___ F ___

Date of Birth (Month/Day/Year) ____/____/____ Social Security # (if available) _____

Parent/Guardian Name _____

Is it permitted for our staff to leave you a voicemail regarding medical information/lab results? Yes _____ No _____

If yes, what is the best telephone number at which to leave this information? _____

Race: ___American Indian ___Asian ___Caucasian ___Person of Color ___Other/Specify _____

Ethnicity: Are you Hispanic or Latino? ___Yes ___No

Native/Primary Language _____ Language Preferred _____

Please provide the following information as well as a clear copy of the front and back of your insurance card (domestic students only):

Insurance Name _____ Policy Name _____

ID# _____ Group # _____

Effective Date (Month/Day/Year) ____/____/____ Phone Number (Providers): _____

Policyholder's Name _____ Relationship to child _____

Policyholder's Date of Birth (Month/Day/Year) ____/____/____

Address (if different) _____ City _____ State _____ Zip _____

Does your insurance require a referral? Yes _____ No _____

If applicable, should we collect co-pay from student or parent/guardian? (circle one)

Who do we bill for deductibles and/or co-insurance balances?

Name _____

Address _____ City _____ State _____ Zip _____

Pharmacy Name: Kent Station Pharmacy
Phone#: (860) 927-3725 Fax: (860) 927-3895
Address: 38 N. Main St. P.O. Box 672 Kent, CT 06757

I authorize the doctor to release any information including the diagnosis and records of any treatment or examination of my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me.

 Signature of Responsible Party: _____ Date: _____

Dear Parent/Guardian:

To protect our students and their families, The Marvelwood School requires that every student be covered by a comprehensive insurance plan. The plan must cover illness and injury, and be accepted by our local providers and practitioners. It is your responsibility to contact your insurance company regarding the benefits available to your child while he/she is a student at the Marvelwood School.

Domestic Students:

Please provide a clear copy of the front and back of your health insurance and prescription drug cards and complete all insurance information as indicated on the **Student Information for School Physician form**.

International Students:

All international students will be enrolled in the Marvelwood School student health plan. The cost for coverage during the school year (10 months) is \$2,260, and will be billed home. Coverage will run 8/15/19 - 6/14/20.

Due to the recommendation by the CDC (Center for Disease Control), the Health Office will be offering the seasonal influenza vaccine for all boarding students. Immunization helps to avoid a flu epidemic on campus during the school year. If you would like your child to receive this vaccination, please complete this form and return it to the Health Office. A fee will be charged to the student's account and will be billed home.*

*If not covered by insurance the fee will be charged to the students account.

STUDENT'S NAME _____ Sex M ____ F ____

Date of Birth (Month/Day/Year) ____/____/____ Telephone Number _____

Address: _____

City _____ State _____ Zipcode _____

Yes ___ No ___ Is the student allergic to gelatin, antibiotics, latex, eggs, thimerosal, or other vaccine component?
If yes, circle which one.

Yes ___ No ___ Has the student ever had a serious reaction to a flu vaccine in the past?

Yes ___ No ___ Has the student ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)
within 6 weeks after receiving a flu vaccine?

Yes ___ No ___ Does the student have long-term health problems with heart, lung, kidney, neuromuscular/neurologic,
liver or metabolic (e.g. diabetes) diseases; or anemia or other blood disorders?

Yes ___ No ___ Does the student have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past
three months, has the student taken medication that weakens the immune system such as cortisone,
prednisone, other steroids, or anticancer drugs; or has the student had radiation treatments?

Yes ___ No ___ Is the student in close contact with a severely immunosuppressed person who requires protective isolation?

CONSENT FOR STUDENT'S VACCINATION

I hereby authorize the Marvelwood School Health Center Staff or other provider to administer the 2019 seasonal influenza vaccine to my child.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

STUDENT'S NAME _____ Sex: M ___ F ___ Date of Birth (Month/Day/Year) ___/___/___

Height _____ Urinalysis: Sugar _____ Albumin _____ S.G. _____ Vision, Uncorrected: R _____ L _____
 Weight _____ Hematocrit/Hemoglobin _____ Vision, Corrected: R _____ L _____
 Blood Pressure _____ Orthodonture/appliances: _____ Glasses _____ Contacts _____ Correction _____
 Pulse _____ Hearing: Right _____ Left _____

Are the following systems normal?	Yes	No	Findings
HEENT, (Chronic Sinusitis?)			
Lymph nodes, Thyroid			
Skin			
Chest, Lungs			
Breasts			
Heart, High/Low Blood Pressure			
Abdomen			
GU, hernia			
Back, Extremities			
Scoliosis/pronation			
Neurologic			
Psychological			

Medications: _____

If yes, please complete Medication Administration Form

Significant Allergies (Drug/Food/Insect): _____ Asthma: _____

If requiring EpiPen, please complete Allergy Requiring EpiPen Form

* Is further evaluation or therapy recommended? _____

* Any significant medical problems not mentioned above? _____

Is the student approved for participation in: Team Sports? Yes _____ No _____ Adventure Sports? (climbing, canoeing, biking) Yes _____ No _____

TB: In high risk group? Yes _____ No _____ *If yes, please report PPD/CXR results on Immunization History Form.*

Tuberculin test required for all international students, high risk domestic students, and students pursuing community service placements in child/elder care.

► Physician, APRN or PA **Signature** (non-parent) _____

Print Name _____ Address: _____

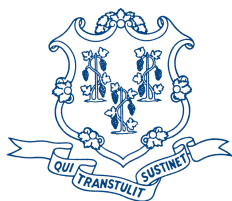
Town, City, Zip _____ Date: _____

* *Physician: Please send a detailed summary of any chronic illness or medical problem including treatment and recommendations.*

Return original or legible faxed or emailed copy to:

**The Marvelwood School
 Health Services
 476 Skiff Mountain Road
 Kent, CT 06757-3001
 Fax: (860) 927-2133
 Email: nurses@marvelwood.org**

*Note to parent: Please schedule all routine medical care (dental, dermatological, etc.) before school starts or during school vacation.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS 2019-2020 SCHOOL YEAR

GRADES 7-12

Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4 th birthday
MMR:	2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday
Meningococcal:	1 dose
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease

- DTaP vaccine is not given on or after the 7th birthday and may be given for all doses in the primary series.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated. Tdap is only licensed for one dose.
- Hib is not required for children 5 years of age or older.
- Pneumococcal is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2019-2020 applies to all Pre-K, K, 1st, 2nd, 3rd & 4th graders born 1/1/07 or later.
- Hep B requirement for school year 2019-2020 applies to all students in grades K-12.
Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 should not be given before 24 weeks of age.
- Second MMR for school year 2019-2020 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2019-2020 applies to all students in grades 7-12
- Tdap requirement for school year 2019-2020 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.
- For the full legal requirements for school entry visit www.ct.gov/dph/cwp/view.asp?a=3136&Q=467374&PM=1
- If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements—they are not considered new entrants.

Commonly Administered Vaccines:

<u>Vaccine:</u>	<u>Brand Name:</u>	<u>Vaccine:</u>	<u>Brand Name:</u>
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Pevnar
HIB-Hep B	Comvax	PCV13	Pevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval

STUDENT'S NAME _____ Date of Birth (Month/Day/Year) ____/____/____

The following immunizations are required for school entry and must be completed before the student arrives at Marvelwood. Please indicate as month/day/year.

- Tuberculin Test:** Required for all international and high-risk domestic students within the year prior to entrance. If student's skin test is positive, you must send a report of the chest x-ray results.
- Diphtheria/Pertussis/Tetanus:** Three doses, provided 3rd dose given on or after 4th birthday, and Td/Tdap booster every ten years thereafter.
- Polio:** Three doses of all IPV or OPV, provided last dose given after 4th birthday.
- Measles/Mumps/Rubella (MMR):** Two doses required; 1st dose after 12 months of age.
- Varicella (Chicken pox):** Two doses or history of disease.
- Hepatitis B (Hep B):** Three doses. Dose one and two are separated by 28 days; dose three is separated from dose one by four months minimum, two months from dose two, on or after age 24 weeks.
- Meningococcal:** One dose at 11-12 years of age; booster at age 16.

The following immunizations are highly recommended:
Human Papillomavirus (HPV): Now highly recommended for males as well as females.
Hepatitis A (Hep A): Now highly recommended

Tuberculin Test and Immunizations:

Tuberculin Test:
 PPD Date:* ____/____/____ Result _____ mm induration
 If positive skin test: Date of CXR ____/____/____ Please provide a copy of CXR report
 TB Therapy initiated? Yes ____ No ____
 BCG: Date ____/____/____ *PPD required regardless of prior BCG vaccination
 This domestic student is at low risk for TB

If no pertussis containing vaccine within the past five years (DTaP, Tdap), then Tdap is highly recommended.

Diphtheria, Pertussis, Tetanus:
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____
 Date of dose 3 ____/____/____
 Date of dose 4 ____/____/____
 Date of dose 5 ____/____/____ Most recent booster ____/____/____

Polio:
 Date of dose 1 ____/____/____ OPV / IPV (circle one)
 Date of dose 2 ____/____/____ OPV / IPV (circle one)
 Date of dose 3 ____/____/____ OPV / IPV (circle one)
 Date of dose 4 ____/____/____ OPV / IPV (circle one)

Flu Shot:
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____
 Date of dose 3 ____/____/____
 Date of dose 4 ____/____/____

Measles, Mumps, Rubella (MMR):
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____

Hepatitis A:
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____

Varicella (chicken pox):
 Hx of disease Date _____
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____

HPV:
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____
 Date of dose 3 ____/____/____

Hepatitis B:
 Date of dose 1 ____/____/____
 Date of dose 2 ____/____/____
 Date of dose 3 ____/____/____

Meningococcal Vaccine:
 Date of dose 1 ____/____/____ Menomune / Menactra (circle one)
 Date of dose 2 ____/____/____ Menomune / Menactra (circle one)

Other Immunizations:

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber and parent/guardian written authorization for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Parents/Guardians: please have the prescribing physician complete and sign this form, then sign and date where indicated. Completed forms should be returned to the Marvelwood School Health office. Use additional forms if necessary.

Name of Student: _____ Date of Birth (Month/Day/Year) ____/____/____

Allergies: _____

Medication Name	Dosage	Route	Frequency	Administration dates: to/from	Known Side Effects

► **Prescriber's Signature:** _____ Date: _____

Prescriber's Name/Title: (TYPE, PRINT OR STAMP) _____

Prescriber's Address: _____

Prescriber's Telephone: _____ Fax: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby authorize that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this 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/Guardian fills out this section:

STUDENT NAME (Last, First, MI): _____

Primary Parent/Guardian Name: _____

Primary Parent/Guardian Contact Number: _____

Physician Name: _____

Physician Phone Number: _____

Physician, APRN or PA completes the rest of the form:

HISTORY OF ASTHMA:

Diagnosis: _____

Check all that apply to this student:

High risk for severe reaction

Food Allergy

Stinging Insect

Specific Allergens: _____

Indicate the sequence to follow when student has ingested, or thinks he/she may have ingested above-named food, or is stung by an insect. **Number from 1 (most urgent) to 6:**

_____ Observe student for symptoms of anaphylaxis**

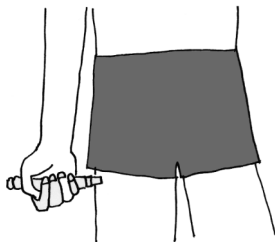
_____ Administer epinephrine BEFORE symptoms occur

_____ Administer epinephrine IF symptoms occur

_____ Administer Benadryl _____mg

_____ Transport to ER if symptoms occur

_____ Call 911 EMS and transfer to ER if EpiPen given



**Symptoms of anaphylaxis include:

Mouth: Itching, swelling of lips and/or tongue

Throat: Itching, tightness/closure, hoarseness

Skin: Itching, hives, redness, swelling

Gut: Vomiting, diarrhea, cramps

Lungs: Shortness of breath, cough, wheeze

Heart: Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly. Some symptoms are life-threatening! Act Fast!

Physician Signature: _____ Date: _____