

STUDENT EMERGENCY CONTACT FORM 2019-2020
 COOPERATIVE EDUCATIONAL SERVICES
 DIVISION OF SPECIAL EDUCATION

Circle Program Your Child Attends:

PLC

DLC

TDP

TLC

Student's Last Name _____ First Name _____ Middle Name _____ Birthdate _____

Student's Address _____ Town _____ Zip Code _____ Home Phone _____

Email: _____

Student lives in the same home with (circle all that apply): Both Parents Mother Father

Stepmother Stepfather Foster Parent(s) Guardian Others (please list) _____

1) Parent/Guardian Name: _____ Work Phone _____ Cell Phone _____

2) Parent/Guardian Name: _____ Work Phone _____ Cell Phone _____

Please list other Parent/Guardian Phone number which may be different than above:

PERSONS TO CONTACT IN CASE OF EMERGENCY IF PARENT/GUARDIAN CANNOT BE REACHED: (LIST SOMEONE OTHER THAN YOURSELF/PARENT/GUARDIAN)

1) Name _____	2) Name _____
Relationship to child _____	Relationship to child _____
Address _____	Address _____
Phone Numbers _____	Phone Numbers _____

LIST HEALTH CARE PROVIDER INFORMATION, PRIMARY CARE PROVIDER AND SPECIALISTS:

Dr. Name	Dr. Specialty	Address	Phone #

**COOPERATIVE EDUCATIONAL SERVICES
DIVISION OF SPECIAL EDUCATION
CURRENT HEALTH STATUS FORM 2019-2020**

STUDENT'S NAME: _____

DATE: _____

MEDICATIONS : List all medication whether given at home or in school. Medication given at school **MUST** have a doctor's order. This includes, but not limited to, daily medications, emergency medications, inhalers)

Medications	Dose	How Often	Reason Given	To be given at school (please check X)	Given at home (please check X)	Doctor's Name

ALLERGIES

My child **DOES NOT** have any allergies.

My child has allergies (please list allergies & reactions)

ASTHMA

My child **DOES NOT** have asthma.

My child has asthma.

SEIZURES

My child **DOES NOT** have a seizure disorder.

My child has a seizure disorder.

Any additional information or medical history that we need to be aware of: _____

PARENT/GUARDIAN SIGNATURE

DATE

**COOPERATIVE EDUCATIONAL SERVICES
DIVISION OF SPECIAL EDUCATION
PERMISSION FOR MEDICAL DECISIONS AND TREATMENT 2019-2020**

STUDENT'S NAME: _____ DATE: _____

The C.E.S. school nurses have permission to use standing orders from an advising doctor, Robert Chessin, MD, when necessary or for emergencies. We provide these services/treatments to help your children, if you are opposed to any of these orders please inform the nurse's office in writing or attach a note to emergency form.

School Nurse may administer Oxygen when indicated for respiratory distress

Allergic Reactions: Attempt to contact primary physician and parent/guardian prior to administering the following:

- a) For reaction with hives, swelling, puffiness or signs and symptoms of initial allergic reaction administer Diphenhydramine HCL (Benadryl) according to the following dosage:
- | | | |
|-----------------------------------|---------------------------|-----------------------------|
| Age: <u>Under 1 year</u> | <u>1 to 12 years</u> | <u>Over 6 years</u> |
| Weight: <u>Under 20 lbs</u> | <u>20 lbs to 45 lbs</u> | <u>(1/2 mg/lb per dose)</u> |
| Dose: <u>6.25 mg. to 12.5 mg.</u> | <u>12.5 mg. to 25 mg.</u> | <u>25 mg. to 50 mg.</u> |
- b) For severe allergic reaction or anaphylactic shock, administer EPI-PEN according to the following dosage:
- | | |
|------------------------------|-----------------------------|
| Weight: <u>Under 45 lbs.</u> | <u>Over 45 lbs.</u> |
| Dose: <u>EPI-PEN Jr.</u> | <u>EPI-PEN ADULT</u> |
| <u>(Adrenaline 0.15mg.)</u> | <u>(Adrenaline 0.3 mg.)</u> |
| <u>(1:2000 solution)</u> | <u>(1:1000 solution)</u> |

Minor Cuts or Abrasions: After cleansing with soap and water apply Bacitracin or Neosporin-type ointment (topically) & DSD prn

Insect Bites: Calamine or Caladryl lotion (topically) prn

Poison Ivy or Other Contact Dermatitis Rash: Calamine or Caladryl lotion (topically) prn

Chapped Lips: Petroleum Jelly (topically) prn

Minor Burns: cold water or ice and/or 2nd Skin (Moist Gel pads) topically prn

2nd Degree Burns: After cleansing apply DSD prn and refer for medical treatment

3rd Degree Burns: Cover with DSD and send to ER or call 911

*Headache, Dysmenorrhea, Orthodontal pain, Generalized Pain or Fever of 101 or Above: Acetaminophen and

Ibuprofen may only be administered with the permission from the Parent or Guardian.

ACETAMINOPHEN:

AGE:	<u>3 yrs</u>	<u>4-5 yrs</u>	<u>6-8 yrs</u>	<u>9-10 yrs</u>	<u>11 yrs</u>	<u>12yrs & up</u>
Weight:	<u>24-36 lbs</u>	<u>37-47 lbs</u>	<u>48-59 lbs</u>	<u>60-71 lbs</u>	<u>72-95 lbs.</u>	<u>over 95 lbs.</u>
Dose:	<u>160 mg.</u>	<u>240 mg.</u>	<u>320 mg.</u>	<u>400 mg.</u>	<u>480 mg.</u>	<u>650 mg.</u>

IBUPROFEN:

AGE:	<u>2-3 yrs.</u>	<u>4-5 yrs.</u>	<u>6-8 yrs.</u>	<u>9-10 yrs.</u>	<u>11 yrs.</u>	<u>12 yrs. & up</u>
WEIGHT:	<u>24-35 lbs.</u>	<u>36-47 lbs.</u>	<u>48-59 lbs.</u>	<u>60-71 lbs.</u>	<u>72-95 lbs.</u>	<u>over 95 lbs.</u>
DOSE	<u>100 mg.</u>	<u>150mg.</u>	<u>200mg.</u>	<u>250 mg</u>	<u>300mg.</u>	<u>400 mg.</u>

- Student weight determines dose of Acetaminophen and Ibuprofen

In the event of a medical emergency, The Good Samaritan Act allows and protects C.E.S. staff who provide emergency care and first aid from being held liable for civil damages for any personal injury which results from acts or omissions. This immunity does not apply to acts or omissions constituting gross, willful or wanton negligence.

Every attempt will be made to contact the parent/guardian in the event of an emergency situation.

PARENT/GUARDIAN SIGNATURE

DATE

COOPERATIVE EDUCATIONAL SERVICES
HIPPA-Compliant Authorization for Exchange of Health and Education Information
Form 2A

Patient/Student Name: _____	Date of Birth _____
I hereby authorize _____ (Health Care Provider Name, Address and Telephone Number)	
To release my/my child's health information/records for the purpose listed below to:	
(Name and title of school official) _____	(Telephone number) _____
_____ (Name and address of school)	

Description: The health information to be disclosed consists of: Medical history and immunizations including diagnosis/goals/treatments. <u>Psychiatric regarding diagnosis/treatment and medication intervention.</u> Other: _____ The education information to be disclosed consist of: <u>Progress and achievement reports.</u> Behavioral data and information. Individualized Education Plan Other: _____ Purpose: This information will be used for the following purpose(s): 1. Educational Evaluation and program planning 2. Health assessment and planning for health care services and treatment in school 3. Medical evaluation and treatment 4. Assessment and planning for treatment of psychiatric, emotional and social needs 5. Other _____

Authorization	
<u>This authorization is valid for one calendar year. It will expire on _____ . I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.</u>	
_____	_____
Parent or Guardian Signature	Date
_____	_____
Student Signature*	Date
*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Connecticut, a competent minor, depending on age, can consent to outpatient mental healthcare, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.	

Copies: Parent or Student* Physician or other health care provider releasing the protected information School official requesting/receiving the protected health information
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