Form #1

STUDENT EMERGENCY CONTACT FORM 2020-2021

COOPERATIVE EDUCATIONAL SERVICES
DIVISION OF SPECIAL EDUCATION

Circle Program Your Child Attends:

PLEASE PRINT

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 EMERENCY 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 #

Form #2

COOPERATIVE EDUCATIONAL SERVICES
DIVISION OF SPECIAL EDUCATION
CURRENT HEALTH STATUS FORM 2020-2021

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**

Form #3

COOPERATIVE EDUCATIONAL SERVICES
DIVISION OF SPECIAL EDUCATION
PERMISSION FOR MEDICAL DECISIONS AND TREATMENT 2020-2021

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:	Under 1 year	1 to 12 years	Over 6 years
Weight:	Under 20 lbs	20 lbs to 45 lbs	(1/2 mg/lb per dose)
Dose:	6.25 mg. to 12.5 mg.	12.5 mg. to 25 mg.	25 mg. to 50 mg.

b) For severe allergic reaction or anaphylactic shock, administer EPI-PEN according to the following dosage:

Weight:	Under 45 lbs.	Over 45 lbs.
Dose:	EPI-PEN Jr. (Adrenaline 0.15mg.) (1:2000 solution)	EPI-PEN ADULT (Adrenaline 0. 3 mg.) (1:1000 solution)

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

IBUPROFEN:

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

- **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**

Form #4

COOPERATIVE EDUCATIONAL SERVICES
DIVISION OF SPECIAL EDUCATION
2020-2021 SCHOOL YEAR

Student's Name: _____

"PERMISSION FORM TO ADMINISTER EMERGENCY CARE"

I understand an emergency may occur and that it may be necessary for my child to receive emergency care on the advice of a health care provider or clinical staff in a hospital. I realize that if my prior written consent were necessary, delay in treatment of the child might be harmful to the health or life of the child. I, therefore, authorize COOPERATIVE EDUCATIONAL SERVICES to consent on my behalf to treatment of my child for any condition suddenly arising which requires such treatment including medical and hospital treatment.**

Health Insurance Information: **Student's Social Security #** _____

1. Do you have Husky Medical Insurance or State Insurance Card? Yes No

   If yes, list Client I.D. # _____
   Child's Health Plan: _____ (i.e., HealthNet, Anthem, ConnectiCare)
   Member ID # _____

2. If you have private insurance:

   Name of Insurance Co. _____
   Name of Insured _____
   Policy I.D.# _____ Individual Member # _____

3. My child does not have insurance: _____

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

**Signature is required if a student is younger than 18 years of age or if a student is 18 years of age or older and guardianship has been obtained by parent/other.

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.
Psychiatric regarding diagnosis/treatment and medication intervention.
Other: _____
The education information to be disclosed consist of:
Progress and achievement reports.
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

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.

_____
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