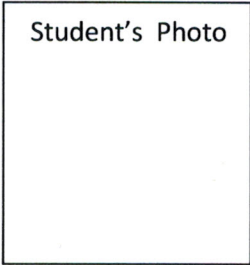


Stonington Public Schools

Emergency Care Plan & Medical Authorization Form

Connecticut State Law and Regulations 10-21(a) require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) 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.

PRESCRIBER'S AUTHORIZATION



Student's Name: _____ DOB: _____

Teacher's Name: _____ Grade: _____

Allergic to: Peanut Tree nuts Insect Stings Latex

Other _____

Asthmatic: Yes ** No **Higher Risk for Severe Reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Mouth: Itching, tingling Epinephrine Antihistamine

Skin: Hives, itchy rash Epinephrine Antihistamine

Face: Swelling of lips, tongue, mouth, or face Epinephrine Antihistamine

Lung: Shortness of breath, repetitive coughing, wheezing Epinephrine Antihistamine

Throat: Tightening of throat, hoarseness Epinephrine Antihistamine

Gut: Nausea, abdominal cramps, vomiting, diarrhea Epinephrine Antihistamine

Heart: Thready pulse, low blood pressure, fainting, pale, blueness Epinephrine Antihistamine

*****If reaction is progressing (several of the above areas affected), give Epinephrine Antihistamine**

*****IF IN DOUBT, ALWAYS ERR ON THE SIDE OF SAFETY AND GIVE EPINEPHRINE*****

Dosage: **Epinephrine:** Inject IM EpiPen 0.3mg / Auvi-Q 0.3mg EpiPen Jr 0.15 mg / Auvi-Q 0.15 mg

Antihistamine: Give _____
(Medication/Dose/Route)

Medication shall be administered from (dates) _____ to _____

Student may self administer medication on field trips: Yes No

Student may self administer medication in school: Yes No

Relevant side effects: _____

*****IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.*****

Physician/APRN Signature: _____ **Date:** _____

Name (Print): _____ **Phone Number:** _____

Address: _____

Emergency Contact Information:

Name	Relationship	Home Phone	Work Phone	Cell Phone

Even if parent/guardian cannot be reached, do not hesitate to medicate or take child to medical facility!

I have received, reviewed, and understand the above information.

Parent/Guardian Signature _____ **Date:** _____

School Nurse Signature _____ **Date:** _____