STUDENT EMERGENCY CONTACT FORM 2025-2026

Circle the School Your Child Attends:

Oakview Primary School **Oakview Middle/High School** **Oakview Transition Program** **Merit Academy**

____ _________________
Student's Last Name **First Name** **Middle Name** **Birthdate**

____ _________________
Student's Address **Town** **Zip Code** **Home Phone**

Parent/Guardian 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_________________________________

Relationship to child_____________________

Address_________________________________

Phone Numbers__________________________

2) Name_________________________________

Relationship to child_____________________

Address _________________________________

Phone Numbers__________________________

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

Dr. Name	Dr. Specialty	Address	Phone #

CURRENT HEALTH STATUS FORM 2025-2026

STUDENT'S NAME: ________________________________ **DATE:** ________________

MEDICATIONS: List all medications 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, and inhalers.

Medication	Dose	How Often	Reason Given	Is medication given at school or at home?	Doctor's Name

ALLERGIES

_____ My child **DOES NOT** have allergies	_____ My child **HAS** allergies (please list allergies and reactions below) ________________________________ ________________________________ ________________________________

ASTHMA

_____ My child **DOES NOT** have asthma	_____ My child **HAS** asthma

SEIZURE DISORDER

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

Chronic Medical Conditions/Devices: ________________________________

____

____

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

____

____

________________________________ ________________

PARENT/GUARDIAN SIGNATURE **DATE**

PERMISSION FOR MEDICAL DECISIONS AND TREATMENT 2025-2026

STUDENT'S NAME: ____DATE: __________________

The C.E.S. School nurses have permission to use standing orders from an advising doctor, Mark Vincent, MD, when necessary &/or for any emergencies. ***If you are opposed to any of these orders, please inform the nurse's office in writing or attach a note to the emergency form.***

The School Nurse under specified conditions may administer the following (please note: PRN stands for "as needed"):

School Nurse may administer Oxygen when indicated for Respiratory Distress/Cyanosis (bluish colored mouth/skin).

Allergic Reactions (unknown reactor): Attempt to contact primary physician &/or parent/guardian prior to administering the following if a mild reaction:

a) **For mild reaction with hives, mild swelling, or mild GI symptoms - administer Diphenhydramine HCL (Benadryl) according to the following dosage:**

Weight:	**22-32 lbs.**	**33-43 lbs.**	**44-54 lbs.**	**55-65 lbs.**	**66-76 lbs.**	**77-87 lbs.**	**88 lbs. & above**
Dose:	**12.5 mg.**	**18.75 mg.**	**25 mg.**	**31.25 mg.**	**37.5 mg.**	**43.75 mg.**	**50 mg.**

b) **For severe allergic reaction or anaphylactic shock, administer EPI-PEN according to the following dosage then call 911 & parent/guardian:**

Weight:	**33 to 66 lbs.**	**66 lbs. or over**
Dose:	**EPI-PEN Jr./Epinephrine (Adrenaline 0.15 mg PRN)**	**EPI-PEN ADULT/Epinephrine (Adrenaline 0.3 mg PRN)**

Minor Cuts or Abrasions: After cleansing with soap/water, BZK wipes, or Normal Saline, apply a thin layer of Bacitracin or triple antibiotic ointment topically to the affected area prn and cover with dry clean dressing or band-aid.

Insect Bites, Reddened Skin Irritations, or any Pruritic (itchy) Rash: Apply thin layer of Calamine, Calagel, Caladryl lotion, or hydrocortisone cream 1% topically to affected area prn.

Chapped Lips, Minor Skin Irritations, or Dry Skin: Apply thin layer of Petroleum Jelly topically to affected area prn.

Oral Care: Saltwater or saline solution oral rinse prn. Can use dental wax to cover any sharp edges of braces prn.

Burns: Run cool water over minor burn x at least 5 min. prn. If more extensive burns - cover with clean non-stick dressing and refer for medical evaluation. Call 911 if the burn is deep, large/severe, involves a sensitive body part, or for any chemical or electrical burns.

***Headache, Dysmenorrhea, Orthodontic pain, Generalized Pain/Discomfort or Fever of 100.0 F or Above:** Acetaminophen or Ibuprofen may only be administered with permission from the parent/guardian. A parent/guardian signature below signifies permission for the 2025 - 26 school year. Notify parent/guardian of use. Student's weight determines the dose (see below).

ACETAMINOPHEN: orally (every 4 hrs.) prn

Weight:	24-35 lbs	36-47 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: orally (every 6-8 hrs.) prn

Weight:	24-35 lbs.	36-47 lbs.	48-59 lbs.	60-71 lbs.	72-95 lbs.	over 95 lbs.
Dose:	100 mg.	150 mg.	200 mg.	250 mg	300 mg.	400 mg.

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**

Mark Vincent, M.D., CES Medical Advisor Signature on File

PERMISSION TO ADMINISTER EMERGENCY CARE, 25-26 SCHOOL YEAR

Student's Name: ____

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.**

Student's Social Security # ____________________

Health Insurance Information:

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.

2025-26 MEDICAL GUIDELINES FOR A STUDENT'S EXCLUSION FROM SCHOOL

The exclusion period for students with a communicable disease is as stated in the table below.

Disease or Symptoms	**Period of Exclusion**
Infectious illness suspected to be contagious	Return to school with a healthcare provider's note.
Signs and symptoms indicative of COVID-19	Until symptoms improved/fever free for 24 hours or more **without** the use of medication.
Fever of 100 degrees Fahrenheit or more (oral, tympanic, or temporal)	Must stay home the following full school day. May return to school once fever free for 24 hours **without** the use of medication.
Respiratory/Flu-like symptoms (Flu, RSV, Pneumonia, etc.)	Until symptoms improved/fever free for 24 hours or more **without** the use of medication.
Stomach virus: Vomiting or Diarrhea (if sent home by nurse **or** occurs 2 times or more in 24 hours at home)	Must stay home the following full school day. May return to school once symptom free for 24 hours **without** the use of medication.
Cold virus symptoms with excessive yellow/green nasal drainage or constant cough	Until nasal drainage is clear and cough is non-productive/only occasional, energy level is normal.
Throat or skin infection requiring antibiotics (i.e., strep throat)	Until diagnosed by a healthcare provider who provides a note that the student is under adequate treatment/medication for 24 hours.
Pink or draining eye (i.e., conjunctivitis)	Until diagnosed by a healthcare provider who provides a note that the student is under adequate treatment/medication for 24 hours.
Any skin rash which may be contagious (i.e., scabies, impetigo, etc.)	Until diagnosed by a healthcare provider who provides a note that the student is under adequate treatment/medication for 24 hours.
Pediculosis or lice	Until treatment is given.
Any childhood vaccine preventable disease (i.e., chicken pox, measles)	Due to immunizations currently available, we no longer expect to see Childhood Diseases. All suspected cases must be assessed by your healthcare provider who provides a note that the student can return to school. May require DPH approval as needed.
Ringworm	Until diagnosed by a healthcare provider who provides a note that the student is under adequate treatment/medication use. Area to be covered if exposed while at school.
Sign or symptom of head injury/concussion	Return to school with a healthcare provider's note that indicates if the student has any school/gym restrictions.
Tuberculosis (active)	Until healthcare provider's note and the local Health Department clears the student to return.
PLEASE NOTE: ~**Orthopedic Injuries** (casts, splints, slings/ace wraps, crutches, orthopedic boots, etc.) ~**Post-Surgical Procedures &/or Dental procedures with general anesthesia**	**Upon return:** Must provide a healthcare provider's note specifying exact return date, any school/gym restrictions, any necessary orthopedic device use, any specific nursing needs, and when treatment/restrictions end after follow-up care is completed (as applicable). **Student will be sent home without such note.**

Mark Vincent, M.D., CES Medical Advisor Signature on File

PARENT/GUARDIAN PERMISSION/REFUSAL OF OPIOID ANTAGONIST (NARCAN) FOR EMERGENCY FIRST AID IN THE CASE OF A SUSPECTED OPIOID OVERDOSE

Connecticut General Statutes 10-212a authorizes school nurses and qualified school employees to administer opioid antagonists for the purpose of emergency first aid to students who experience an opioid related overdose. For the purposes of this policy, "opioid antagonist" means naloxone hydrochloride (Narcan) or any other similarly acting drug approved by the federal Food and Drug Administration for the treatment of a drug overdose. Opioid antagonists are safe drugs with little to no side effects, though there are rare cases of allergic reactions.

In the case of a student experiencing an opioid overdose, staff will alert the school nurse and program administrator who will follow emergency first aid procedures: calling 911, checking for student response, administering opioid antagonist (parent permitting), and monitoring student in rescue/recovery position. Following administration of an opioid antagonist, the student's parent/guardian, the program administrator(s), and the Executive Director of C.E.S. will be notified. Records will be kept by the Director of Related Services and Special Programs with respect to the administration of an opioid antagonist.

☐ I **do** want Naloxone (Narcan) to be given to my child if needed for a suspected opioid overdose.

☐ I do **NOT** want Naloxone (Narcan) given to my child under any circumstances.

______________________________ ______________

Student Name | Student Date of Birth

____

Parent/Guardian Name

______________________________ ______________

Parent/Guardian Signature | Date

Revised 3/2025

HIPAA-Compliant Authorization for Exchange of Health and Education Information Form 2A

Please complete information for all applicable health care providers.

Patient/Student Name: ____ **Date of Birth:**____________

I hereby authorize: ____

(Pediatrician Name, Address and Telephone Number)

____

(Psychiatrist/Psychologist Name, Address and Telephone Number)

____

(Neurologist Name, Address and Telephone Number)

____

(Gastroenterologist Name, Address and Telephone Number)

____

(Other Specialist 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 HIPAA 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