

# 2026-2027

## NORTHWESTERN REGIONAL SCHOOL DISTRICT 7 Student Health Emergency Information

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_  
(Last) (First) (Middle)

Does your student have Health Insurance Yes No Would you like information about CT HUSKY Plan? Yes No

**Instructions: Please indicate the relevant responses below.**

\* Please provide the required provider-signed medical authorization form for any medications your student will need.

<b>ALLERGIES</b>	Yes	No	<b>CARDIAC PROBLEMS</b>	Yes	No
Please list any food, medication or bee allergies:			Please indicate cardiac conditions:		
Is allergy life threatening	Y	N	Restrictions for Physical Activity	Y	N
Does Student Need Epi Pen *	Y	N	Does student have a pacemaker	Y	N
Student will self-carry Epi Pen*	Y	N	Does student have a defibrillator	Y	N

<b>ASTHMA</b>	Yes	No	<b>DIABETES</b>	Yes	No
Does student need rescue inhaler*	Y	N	Does student use CGM	Y	N
Student will self-carry inhaler*	Y	N	Does student use insulin pump	Y	N

<b>SEIZURES</b>	Yes	No	Type:
Please indicate the type of seizures:			
Does student need Diastat*	Y	N	*Please provide Diabetes Management Plan & Contact Health Office regarding nurse access to CGM monitoring
Does student need nasal Midazolam*	Y	N	*Parents must maintain supplies in Health Office

**OTHER HEALTH CONDITIONS**  
please explain:

Does student take any medicine at home on a regular basis? Reason Taking?

Does student need to take any medicine at school? Reason Taking?

*\* Physician Medication Authorization Form REQUIRED for each medication to be administered in school with the exception of standing order for Tylenol or Ibuprofen. Medication must be delivered by parent or guardian. \* I understand that no student may carry any prescription or over-the-counter drug in school or on school property with the exception of emergency medications: rescue inhalers, Epi pens or insulin.*

*\* I, the undersigned parent/guardian, give permission to the school nurse to exchange pertinent health information as related to health & safety about my child with his/her teacher.*

*\* In the event of an emergency, I understand that every effort will be made to reach the parents. In the event I cannot be reached, I give permission for my child to be transported to the appropriate medical facility.*

Parent Signature

Student Signature

# NORTHWESTERN REGIONAL SCHOOL DISTRICT 7

BARKHAMSTED, COLEBROOK, NEW HARTFORD and NORFOLK



August 2026

Dear Parent / Guardian:

Our medical advisor Dr. Ann Milanese has provided a standing order for the administration of Regular Strength **Tylenol/Acetaminophen** (325 mg) tablets or **Ibuprofen**(200mg) tablets, to be used in the case of a minor headache, fever, orthodontic discomfort, menstrual discomfort and/or muscle cramps. A standing order for the administration of regular strength **Tums** antacid tablets as directed for the relief of stomach upset or indigestion is also provided.

This order in no way changes the general medication administration policy of the school district.

**NO MEDICATION, PRESCRIPTION OR OVER-THE-COUNTER MAY BE ADMINISTERED WITHOUT A SIGNED DOCTORS ORDER AND PARENT CONSENT.**

Please complete the form below and have your child return the entire form to the Health Office. Any questions, please call the Health Office.

Dorothy Mitchell, RN  
860-379-8525 Ext. 2618

Amanda D'Urso, RN  
860-379-8525 Ext. 2619

## 2026 – 2027 School Year

The School Nurse has permission to administer to my child (please check all that apply) in keeping with the school's standing order as given by Dr. Ann Milanese, medical advisor.

Tylenol / Acetaminophen (325 mg) - 1 tablet \_\_\_\_\_ Ibuprofen (200 mg) - 1 tablet \_\_\_\_\_

Tylenol /Acetaminophen (325 mg) - 2 tablets \_\_\_\_\_ Ibuprofen (200 mg) - 2 tablets \_\_\_\_\_

Tums/Antacid – 1 tablet \_\_\_\_\_

Tums/Antacid – 2 tablets \_\_\_\_\_

Above noted medication Not Required \_\_\_\_\_

\_\_\_\_\_  
Student Name (Please Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Date

# NORTHWESTERN REGIONAL SCHOOL DISTRICT 7

## SCHOOL MEDICATION AUTHORIZATION

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, qualified school personnel to administer medication. Medications must be in the original properly labeled container. Prescription medication should be in the labeled container dispensed by a pharmacist.

This authorization is in effect for the school year: 2026 – 2027 To include extended year program.

Self-administration of asthma inhalers and cartridge injectors (for medically diagnosed allergies) may be authorized by the prescriber and school nurse, when applicable, and must be authorized by the parent/guardian, in accordance with Board policy to confirm student safety and competency with medication procedure.

### Prescriber's Authorization

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Condition for which medication is indicated: \_\_\_\_\_ Medication Allergies  NKDA  Yes: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route:  mg  puffs  amp  other  PO  GT / NGT  Inhaled  Injected

Time of Administration \_\_\_\_\_  AM  PM Side Effects: \_\_\_\_\_  Not relevant

If PRN, frequency, Q \_\_\_\_\_ Hours Medication shall be administered Start date: \_\_\_\_\_ End date: \_\_\_\_\_

<p><b>Prescriber's Authorization for Self-Administration</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Confirms that the student has been instructed to safely and properly administer this medication</i></p>	<p><b>Provider Name &amp; Phone/Fax Numbers (printed or stamped)</b></p>
<p>Prescriber's Signature _____ Date: _____</p>	

### Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a **3-month supply of medication**. I understand that this medication will be destroyed if not picked up following discontinuation of the medication or the last day of school, whichever comes **first**.

*I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe administration of this medication and the safe management of the condition for which it is prescribed.*

**Parent/Guardian Authorization for Self-Administration**  Yes  No

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Home Phone# \_\_\_\_\_ Work/ Cell # \_\_\_\_\_

**School nurse approval for Self-Administration**  NR\*  Yes  No \_\_\_\_\_

\*NR mean Not required for inhalers or cartridge injectors Signature \_\_\_\_\_ Date \_\_\_\_\_

Dorothy Mitchell, RN  
[dmitchell@nwr7.org](mailto:dmitchell@nwr7.org)  
860-379-8525 Ext-2618

Fax: 860-379-8940  
Hours: 7:30 AM - 2:30 PM

Amanda D'Urso RN BSN  
[adurso@nwr7.org](mailto:adurso@nwr7.org)  
860-379-8525 Ext-2619

## **Health Services Information:**

### **Physical Examinations**

NWR 7 Board policy examination (C.G.S. 10-2045a) mandates that all students must present an updated physical exam:

1. Upon enrollment to the district
2. Prior to 7<sup>th</sup> grade entry (physicals completed during 6<sup>th</sup> grade year will be accepted)
3. During the 9<sup>th</sup> or 10<sup>th</sup> grade year, and prior to 11<sup>th</sup> grade year entry.

The CT Health Assessment Record (Blue) Form must be completed in its entirety to include vision, auditory, scoliosis screenings & immunization updates. Sports physical forms will not be accepted in lieu of mandated health forms.

### **Immunizations**

All students must present proof of immunizations upon enrollment.

Students not immunized due to medical reasons, must provide a completed medical exemption certificate signed by the physician. These forms are available on the district web site.

*\*Only Religious exemptions prior to 4/28/21 are accepted.*

### **Student Health Emergency Information (pink) Form**

This confidential medical information form held on file in the health office, is to assist in providing for the health and safety of your child. This form is to be updated at the start of the new school year.

***If you indicate that your child has asthma or a life-threatening allergy that requires either rescue/emergency medication, you MUST provide both the medication and a physician-signed Medication Authorization form signed by a parent. Without these medications and forms, your child will be excluded from all field trips.***

### **Parental Permission: Over the counter Standing Medication Order (purple)Form**

The district medical advisor has provided a standing order for the administration of Tylenol, Ibuprofen or Tums, in case of minor headache, fever, discomfort or stomach upset. If you feel this would be beneficial for your child, signed parental permission is required. Update forms should be completed at the start of each new school year.

This standing order in no way changes the general medication administration policy. No medication, prescription or Over-the-Counter medication will be administered without a signed physicians order and parental consent

## **Administration of Medication in School**

Nurses must follow CT State law and Board of Education policy re the administration of medicine to your child. Medications are administered during school hours if the desired effect cannot be achieved outside school hours.

1. All medications, including emergency self -carry medications, will be administered only with the following:
  - a. Medication Authorization Form, signed by an authorized prescriber and written authorization of the parent.  
*Law does not permit verbal authorization/request by parents*
  - b. Medication orders are valid for one academic year.
2. All medications must be brought to the health office by an adult with the exception of emergency medications (EpiPens, Inhalers or diabetic supplies) which may be transported by the student.
3. Students who self -carry these emergency medications must have them on their person at all times in case of an emergency (i.e.: a lock down, fire drill etc.)
  - a. Parents are encouraged to provide a backup medication available in the health office in the event the student does not have them on their person.
4. Parents must pick up all unused medication at the end of the school year. Medication not picked up will be disposed of per policy.

## **Physician Notes**

In keeping with FERPA guidelines for confidentiality & privacy, all medical notes must be brought/faxed (860-379-8940) directly to the Health Office.

The nurses will only communicate pertinent information or restrictions to the appropriate staff.

## **Illness or Injury**

If a student becomes injured or ill during school, he/she should report to the Health Office. The nurse will evaluate the child and contact the parent if necessary. Dismissals indicated by the nurse or in following with physician order, 504/IEP or health plan will be medically excused. Parents of students dismissed through the health office are required to sign their child out in the Main Office.

## **Guideline for determining if your child should be in school:**

1. Fever free (less than 100.4) for 24 hours before returning to school without fever reducing medication.
2. No episodes of vomiting for 24 hours.
3. No active communicable and/ or contagious infections.
4. Antibiotics therapy for 24 hours before returning from a communicable infection.
5. Influenza, gastro-intestinal viruses & Covid reporting to the health office is recommend so that health trends maybe monitored.

## **Requirements for Return to School after Surgery or Serious Illness/Injury**

A physician note is required indicating clearance to return to school, after surgery, serious illness, concussion, or hospitalization. These notes should be brought to the Health Office. The note should include any restrictions (i.e.: no physical education) or required accommodations (i.e.: elevator use).

The physician must update continued restrictions.

When these restrictions or accommodations are no longer indicated, documentation from the physician is required.

## **Field Trips**

Students must have an updated Health Emergency (pink form) Form on file in health office. Those who self- carry inhalers, epi pens, or diabetes supplies are expected to bring their medications from home for field trips. If this form is not on file, or medications are not available, your child will be excluded from field trips for their own safety.

## **Sports Participation**

Registration is managed through Family ID/Arbiter Sports. To facilitate the eligibility validation process parents should, complete the online registration at least 2 weeks prior to the start of sports. This will allow the nursing staff ample time to review the registrations.

**Please be advised registration does not confirm eligibility. The following items are required:**

1. Current physical exam from the past 13 months. Forms may be uploaded through Family ID, faxed 860-379-8940, mailed, or delivered directly to the Health Office.  
*Sports physicals will not be accepted in lieu of the CT Health Assessment blue form*
2. No current physician-imposed restrictions from previous injuries or conditions can be in place.  
A note from a medical provider is required for clearance from a current injury or condition that resulted in exclusion from sports.
3. Students returning after recovery from a concussion must provide a physician note to the Health Office indicating clearance and have completed the return to play protocol prior to participation.
4. Athletes who have tested positive for COVID 6 months prior to the season must provide a report of symptoms to the Health Office & check in with the Athletic Director prior to participation.

Please check Family ID to confirm eligibility status or physical exam expiration date. You will receive an email from Family ID 60 days in advance of the expiration date of your physical.

\*Health Services Information and required forms are available on the district website.

## Formulary of First Aid Preparations- For use in the Health Office

Alcohol- Isopropyl	For skin prep
Bacitracin Ointment	For use for minor abrasions
BZK Towelettes	For skin prep
Caladryl, Calamine, Hydrocortisone Cream ½%	For use topically for insect bites or skin irritations
Chloraseptic spray or warm water saline (1:18)	For use for minor throat irritations
Contact Solution	For use for self-cleaning of contacts
Cough Drops	For minor throat discomfort
Diphenhydramine (Benadryl) 12.5mg/5ml or 25mg tablets	For emergency treatment of allergic reaction
Epinephrine 0.15mg or 0.3mg auto-injector	For emergency treatment of allergic reaction
Eye Irrigating Saline Solution, Soothe Eye Drops	For use to flush eyes
First Aid Cream, Burn Gel/ Spray, or Aloe	Topical use for minor burns and skin irritations
Glucose gel or tablets	For the treatment of low blood sugar for students with diabetes
Hydrogen Peroxidex	For use topically to clean wounds
Ibuprofen 200mg tablets	For headaches, menstrual or muscle cramps, pain due to orthodontic adjustments or toothaches
Naloxone (Narcan)	For emergency treatment of opioid overdose
Orajel, Oral pain Relief	Topical use for minor toothache, canker or cold sore, or orthodontic discomfort
Oxygen	May be used for insufficient oxygen intake
Petroleum Jelly, Vaseline or Lotion	Topical use for chapped lips or dry skin
Sting Relief swabs or wipes	Topical use for insect bites or stings
Tylenol /Acetaminophen 325 mg tablets	For headaches, menstrual or muscle cramps, pain due to orthodontic adjustments or toothaches
Tums tablets	For upset stomach or indigestion