EMERGENCY ALLERGY PLAN

(To be completed by the physician)

Student name: _____ DOB: _____Grade/Teacher: _____

DOCTOR: _____Doctor phone: _____

Allergy to: _____

Asthmatic: YES* NO *Higher risk for severe reaction

Signs of allergic reaction include:

MOUTH: itching and swelling of the lips, tongue or mouth
THROAT: itching and/or a sense of tightness in the throat, hoarseness, cough
SKIN: hives, itchy rash, and/or swelling about the face or extremities
GUT: nausea, abdominal cramps, vomiting and/or diarrhea
LUNGS: shortness of breath, repetitive coughing and/or wheezing
HEART: weak pulse, fainting, pale

Specific symptoms unique to this child: _____ _

Action:

The severity of symptoms can change rapidly. All above symptoms can potentially progress to a life-threatening situation.

1. If ingestion, sting, or contact is suspected, give the following medication immediately:

_____

2. Call 911 if epinephrine is given.

3. Call parents:

Mother cell: _____ Father cell: _____

Mother work: _____Father work: _____

Parent responsibilities:

1. Parent will provide emergency medications with the **required physician and parent signed authorization** to the School Nurse. **(see reverse side)**
2. **In order to have students allergy highlighted in the cafeteria computer system, parent must initiate a phone call to 610-932-6660. This must be done every school year!**
3. Upon parent initiation, the District Food Service Director can provide lists of ingredients of items student may wish to purchase in the cafeteria.
4. Parents will provide signed "Medical Condition Release to Bus Drivers" form.
5. Parents may send in safe snacks.
6. Parents will keep the School Nurse updated regarding changes in student's medication and condition.

My child will sit at a peanut free table in the cafeteria. Yes No (circle one)

Parent signature: _____ Date: _____

STUDENT PERMISSION TO CARRY EMERGENCY MEDICATION

This student has received the proper instruction and should be permitted to carry and self-administer the following medication(s):
_____

Physician signature: _____Date: _____

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

OXFORD AREA SCHOOL DISTRICT

****This form must be completed and sent to the School Nurse if your child needs to be given medication during the school day. This includes **all** prescription medications and **all** over-the-counter (OTC) medications (OTC examples: cold/allergy medications, vitamins, herbal supplements.)****

Student's name: ____ Grade: ______________

Date of birth: _________________________ Allergies: ____

List of medications currently being taken by the child:

____

PARENTAL PERMISSION

I, the parent/guardian of _______________________________________ request that the School Nurses of the Oxford Area School District administer the medication named below. I understand that I must give the first dose of this medication at home, and that all medications must be sent in their original pharmacy containers along with signed physician authorization to administer the medication in school. My signature on this document constitutes a complete waiver of liability claim in any and all respects against The Oxford Area School District and its Board of Directors and all of its employees unless the District is negligent with regard to any claim for injury in connection with administration of the medication named below.

I understand that all medications, unless indicated in writing by the physician, must be kept at the Nurse's office and that my child may not carry medication on his/her person during the school day, nor may it be kept in his/her school bag.

Additionally, I agree to provide the medication to the school in the original pharmacy or physician labeled container. If I am unable to deliver it, I will place the container containing the medication with this completed authorization form in a sealed envelope for transport to the school. **I also accept responsibility to provide a physician's note and my written consent if the medication is to be changed or discontinued.** I give permission for the school and our child's physician to communicate regarding this medication/medical condition.

____/__________________________________ /________________

Signature of Parent/Guardian **Daytime Phone Numbers** **Date**

****A new authorization form must be signed (Parent & Physician) each school year.****

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PHYSICIAN AUTHORIZATION FOR MEDICATION

******Medications will not be given without physician's signature******

Name of medication: __________________________________ Route of administration: ______________________

Dose: ____

Time to administer: _______________________________ Discontinuation date: ______________________________

****Asthma inhaler: The student is qualified and able to self-administer the inhaler and may carry the inhaler during the school day per District Policy YES NO NOT APPLICABLE*

Treatment of: ____

Side effects: ____

____ ____

Physician Signature **Printed Name of Physician**

____ ____

Physician Phone Number **Date**