FOXBOROUGH PUBLIC SCHOOLS

Emergency Health Care Plan with Physician's Orders: _____

(All orders are good for one year from date of MD signature)

Student Picture

Student's Name: _____ DOB: _____ Teacher: _____

Address: _____ ,Foxborough, MA

ALLERGIC TO: _____

Asthma Yes ☐ * No ☐ ***High risk for severe reaction if child also has asthma**

SIGNS OF A SERIOUS ALLERGIC REACTION INCLUDE:

Systems	*Symptoms*
Mouth	itching, tingling or swelling of the lips, tongue and/or mouth
Throat*	itching, and/or a sense of tightness in the throat, hoarseness and/or hacking cough
Skin	hives, itchy rash and/or swelling about the face or extremities
Abdomen	nausea, abdominal cramps, vomiting and/or diarrhea
Lung*	shortness of breath, repetitive coughing and/or wheezing
Heart*	tightness of chest, lightheadedness, dizziness, fainting

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

ACTION #1 IS TO BE FILLED OUT BY A LICENSED PRESCRIBER:

- **ACTION #1: If exposure is known OR suspected, give the following:**

☐ Epi-Pen/Auvi Q adult 0.3 mg via auto injector PRN: _____

☐ Epi-Pen/Auvi Q Junior 0.15mg via auto injector PRN: _____

☐ Other Medication (list medication/dose/route): _____

☐ Other Medication (list medication/dose/route): _____

☑ Unless indicated otherwise, any daily medication listed above may be held on field trip days with parental consent: _____

☑

Additional Physician Commnts: _____

_____ _____ _____

Physician Name (Print) **Physician Signature** **Date**

- **ACTION 2: CALL 911 "DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL 911!"**
- **ACTION 3: Call the Parents**
-

Mother's home: _____ **Father's home:** _____

Cell: _____ **Cell:** _____

Work: _____ **Work:** _____

ADDITIONAL EMERGENCY CONTACTS:

1. _____

Relation _____ Home: _____

Cell: _____ Work: _____

2. _____

Relation _____ Home: _____

Cell: _____ Work: _____

_____ _____ _____

Parent Name (Print) **Parent Signature** **Date**

_____ _____

School Nurse Signature **Date**

Does your child wear a Medic Alert ID? Yes_____ No_____

Will your child carry an Epi Pen in backpack? Yes_____ No_____

OVER

PARENT/GUARDIAN AUTHORIZATION: EPI-PEN MEDICATION ADMINISTRATION: TRANSPORTATION/CAFETERIA/FIELD TRIP

Bus Transportation

Students may keep a prescribed EpiPen in their backpack for coverage on the bus to and from school. The bus drivers will be alerted to your child's allergy and they will be trained by a nurse to administer the Epi Pen. We recommend that you tell them about the Epi Pen/Allergies on the first day of school!

I give permission for the bus driver on bus #_____ to administer a prescribed EpiPen to my child, _____ (**print name**) in the event of an allergic reaction.

I understand that if I choose to put an Epi Pen in my child's back pack, it is my responsibility to provide an Epi Pen with a valid expiration date and to check that it is in my child's backpack daily. It must be clearly labeled with the child's name and have a prescription label attached. Please ask the pharmacist to attach the prescription label directly to the Epi Pen. **A picture ID is strongly recommended.** ***Please initial:*** _____

Cafeteria; Field Trip; Emergency

I give permission for a staff member designated and trained by the school nurse to administer an Epi Pen to my child in the cafeteria, classroom, on a field trip, or in any emergency. The same holds true for an inhaler or daily medication that may be ordered on the front page of this form. I understand that, per the Massachusetts Department of Public Health regulation, no PRN [as needed] medication (e.g. Benadryl) will go on field trips.

Please initial: _____

Peanut/Nut Free Tables in the Cafeteria

Please check ONE option below:

☐ I WISH for my child to sit at the **designated peanut/tree nut free table** during lunch in the cafeteria.

☐ I DO NOT wish for my child to sit at the designated peanut/tree nut free table during lunch in the cafeteria. They may sit anywhere they choose. ***Please initial:*** _____

Please check ONE option below! (Check all staff that apply)

☐ I would prefer that information regarding my child's allergy BE SHARED with the following staff:

All cafeteria staff:_____**Classroom teacher:** _____**Bus driver (transportation office):** _____***Please initial:***_____

☐ I would prefer that information regarding my child's allergy NOT BE SHARED with the following staff:

All cafeteria staff:_____**Classroom teacher:** _____**Bus driver (transportation office):** _____***Please initial:***_____

Please sign below:

_____ _____

Parent/Guardian Signature ***Date***

Note: *Students with severe allergies or medical conditions are encouraged to wear* ***MedicAlert*** *identification.*