PRINCE of PEACE CATHOLIC SCHOOL

STUDENT ALLERGY FORM:

(Complete entire form in ink and in print)

Today's Date: _____

Child's Name: _____ DOB: _____ Teacher/Grade:_____

Allergy to: (list all) _____

Asthmatic: _____ YES***(Higher Risk for Severe Reaction)** _____NO

STEP 1: TREATMENT:

Symptoms:	Administer Checked Medication (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*	____ Epinephrine	____Antihistamine
• Mouth – Itching, tingling, or swelling of lips tongue, mouth	____ Epinephrine	____Antihistamine
• Skin – Hives, itchy rash, swelling of the face or extremities	____ Epinephrine	____Antihistamine
• Gut – Nausea, abdominal cramps, vomiting, diarrhea	____ Epinephrine	____Antihistamine
• *Throat - Tightening of throat, hoarseness, hacking cough	____ Epinephrine	____Antihistamine
• *Lung – Shortness of breath, repetitive coughing, wheezing	____ Epinephrine	____Antihistamine
• *Heart – Thready pulse, low blood pressure, fainting, pale, blueness	____ Epinephrine	____Antihistamine
• *Other - _____	____ Epinephrine	____Antihistamine
• If reaction is progressing (several of the above areas affected)	____ Epinephrine	____Antihistamine

*The severity of symptoms can quickly change. *Potentially life-threatening**

Dosage:

Epinephrine: inject intramuscularly (circle one) – EpiPen® EpiPen Jr. ® Twinject™ 0.3mg Twinject™ 0.15mg

Antihistamine: Give _____
(medication/dose/route)

Other: Give _____
(medication/dose/route)

STEP 2: EMERGENCY CALLS:

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr. _____ at _____.
3. Emergency Contacts:

Name/Relationship	Phone Number(s):	
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Parent Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

PRINCE of PEACE CATHOLIC SCHOOL

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

(Complete entire form in ink and in print)

Today's Date: _____

Child's Name: _____ DOB: _____

Name of Medication: _____ Expiration Date: _____

Date medication begins: _____ Date Medication Ends: _____

Does medication need to be refrigerated? _____ YES _____ NO

What is medication for? _____

Instructions for administering medication:

Dosage/Amount _____

Form of administration: (i.e. oral, topical, injection) _____

Time of administration: (Choose appropriate)

- ☐ At set times of day – specify time and AM or PM _____
- ☐ Only when symptoms occur – please describe _____
- ☐ In an emergency – such as with allergic reaction _____

Special administration instructions (i.e. take with food, avoid taking with certain foods)

_____

Possible side effects to watch for:

_____

Possible complications and treatment:

_____

Please note approximate time for medication to take effect: _____

Doctor's Name: _____ Phone: _____

Doctor's Address: _____

Attach additional instructions from doctor or pharmacist as necessary

Parent/Guardian Name (Printed): _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

If not parent, relationship to child: _____

No child will be allowed to carry or dispense medication on their own. ALL medication must be delivered by a parent to the school office in the original container with the child's name on the container and this permission form accompanying it that gives specific instruction for administering. ALL remaining medication MUST be picked up by parents at the end of the year or it will be destroyed. This includes Epi-Pens and inhalers.

PRINCE of PEACE CATHOLIC SCHOOL

Student Name: _____ **DOSING LOG**

DATE	TIME	AMOUNT	SIGNATURE	NOTES

PRINCE of PEACE CATHOLIC SCHOOL

AUTHORIZATION TO ADMINISTER OTC MEDICATION

(Complete entire form in ink and in print)

Today's Date: _____

Child's Name: _____ Teacher/Grade: _____

Name of Medication: _____

Does medication need to be refrigerated? _____ YES _____ NO

What is medication for? _____

Instructions for administering medication:

Dosage/Amount _____

Form of administration: (i.e. oral, topical, injection) _____

Time medication last administered today: _____ AM PM

Time of administration: (Choose appropriate)

- ☐ At set times of day – specify time and AM or PM _____
- ☐ Only when symptoms occur – please describe _____
- ☐ In an emergency – such as with allergic reaction _____

(Parents will be contacted to verify time of AM dose given at home before first dose is given at school.)

Special administration instructions (i.e. take with food, avoid taking with certain foods)

_____

Possible side effects to watch for:

_____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

If not parent, relationship to child: _____

No child will be allowed to carry or dispense medication on their own. <u>ALL</u> medication must be delivered by a parent to the school office in the <u>original container</u> and this permission form accompanying it that gives specific instruction for administering. OTC medication may remain locked in the nurse's office during the school year. Parents will be contacted when medication has expired or needs to be replaced. <u>ALL</u> medication must be picked up at the end of the school year or it will be destroyed.

PRINCE of PEACE CATHOLIC SCHOOL

STUDENT HEALTH AND EMERGENCY FORM

STUDENT'S NAME _____ D.O.B _____ GRADE _____

HOME ADDRESS _____

Street City & Zip Code Home Phone

Please provide the following information for contact in an emergency situation:

_____

Mother's Name Cell # Work #

_____

Father's Name Cell # Work #

List other persons who will assume temporary care of your child if you cannot be reached. Please list persons who are allowed to pick up your child from school. ***(Unless the office has prior notification in writing from the custodial parents, a child cannot be released to anyone not listed on this form.)***

1. _____

Name Relationship Home Phone Cell Phone

2. _____

Name Relationship Home Phone Cell Phone

3. _____

Name Relationship Home Phone Cell Phone

HEALTH INFORMATION: List any health conditions that will help us care for your child. Please include any allergies, asthma, heart conditions, diabetes, epilepsy, A.D.D., etc.

_____

_____

Medication (if any) child may presently be taking (include all regularly taken medications – ***it is important that we are able to notify emergency personnel of any and all medications child is taking in the case that emergency treatment is necessary***):

_____ _____

Name of Medication Dose Name of Medication Dose

_____ _____

Name of Medication Dose Name of Medication Dose

Physician to contact in case of emergency: _____

Name Phone

Preferred hospital: 1. _____ 2. _____

Dentist to contact in case of emergency: _____

Name Phone

Primary Insurance Provider: _____

Name Phone

Policy Holder Name: _____ Contract #: _____

IS YOUR CHILD ALLERGIC TO ANY DRUGS? _____ No _____ Yes, please list _____

I, the undersigned, do herby authorize officials of Prince of Peace Catholic School to contact directly the persons named on this form. I authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of my child.

In the event the parents, physicians or other persons named on this card cannot be contacted, the school's officials are hereby authorized to take whatever action is deemed necessary in their judgment to provide for the emergency care and/or transportation of my child.

_____ _____

Signature of Parent/Guardian Date