FOXBOROUGH PUBLIC SCHOOLS

Emergency Health Care Plan with Physician's Orders: 2021-22 School Year

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

Student Picture

Student's Name:_____DOB:_____Grade/HR:_____

Address:_____

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/epinephrine auto-injector (adult 0.3 mg) via auto injector PRN: _____

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

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

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

☑ Any daily medication listed above may be held on field trip days with parental consent: YES

Additional Physician Commnts:_____

_____ **MD TO FAX to 508-543-1654** _____ _____

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

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

Mother/Guardian:_____ **Father/Guardian:**_____

Cell: _____ **Cell:**_____

Home/Work Phone:_____ **Home /work** _____

_____ **Parent Signature** **Date**_____

ADDITIONAL EMERGENCY CONTACTS:

1._____

Relation_____ Home:_____

Cell:_____ Work:_____

2._____

Relation_____ Home:_____

Cell:_____ Work:_____

_____ **Ahern Middle 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.*