Dear Parent/Guardian of children with Food Allergies,

In an effort to help your child avoid the identified food allergen, we offer the following suggestions for your consideration.

- Provide a medic alert bracelet for your child
- Provide the school with the physician's instructions for treatment of anaphylaxis
- Provide the school with up-to-date medication
- Provide safe foods for special occasions, snacks, field trips
- **It is your responsibility to notify all before/after school programs, extra-curricular activities, play dates etc. regarding your child's allergic condition.**
- Teach your child:
    - To recognize the first symptoms of an anaphylactic reaction
    - To communicate clearly when he/she feels a reactions is starting
    - Not to share snacks, lunches or drinks
    - To report any bullying/threats to an adult in authority
    - To take as much responsibility as possible for his/her own safety

* Welcome other parent's calls with questions about safe foods for planned school activities.

These suggestions will provide extra safety for your child. Thank you for your consideration.

Sincerely,

School Nurse

FOOD/INSECT ALLERGY INFORMATION SHEET

Please complete the following information specific to you child's needs and return it to the School Nurse.

Child's Name:_____ Grade:_____

Physician's Name:_____ Telephone #:_____

Child's Health Problems:_____

Asthma: Yes_____ No_____

Please provide information describing your child's allergy to EACH food, insect, or other allergen. Be as specific as possible.

Food/Insect_____

Check signs usually present during an attack:

_____difficulty breathing
_____wheezing or coughing
_____difficulty swallowing
_____swelling WHERE?_____
_____dizziness
_____loss of consciousness
_____flushed or pale
_____nausea, vomiting, cramps diarrhea
_____ itching WHERE ?_____
_____rash or hives WHERE? _____

Food/ Insect _____

Check signs usually present during attacks:

_____difficulty breathing
_____wheezing or coughing
_____difficulty swallowing
_____swelling WHERE?_____
_____dizziness
_____loss of consciousness
_____flushed or pale
_____nausea, vomiting cramps, diarrhea
_____itching WHERE?_____
_____rash or hives WHERE?_____

Please check if you wish your child to sit at an ALLERGY FREE table in the Cafeteria

Yes_____ No_____

Has hospitalization or other medical treatment been needed in the past for allergies ?

Yes_____ No_____ If yes when?_____

Please describe_____

_____

Please have the attached medications authorization form filled out by child's physician and parent. Return the authorization to school immediately with the needed medication. All medication must be in original container with pharmacy label and brought in by parent/guardian.

_____ _____

Signature of parent/guardian Date

FORM FA-3

NEW CANAAN PUBLIC SCHOOLS

Physician's Emergency Medical Protocol

Physician please complete the following:

Child's Name: _____ Date of Birth: _____

Physician's Name: _____ Telephone #: _____

Child's Diagnosis: _____

Specific Insect/Food Allergen: _____

Has Asthma? Yes or No **(Circle one)**

If the child is stung, or has ingested or thinks he/she has ingested the above named food:

PLEASE IDENTIFY BY NUMBER (1,2,3...) MEDICAL PROTOCOL DESIRED

_____Observe child for symptoms of anaphylaxis

_____Administer Benadryl_____(state specific dose)

_____Administer Epinephrine **(Epi-pen,jr.)** 0.15cc before symptoms occur.

_____Administer Epinephrine **(Epi-pen,jr.)** 0.15cc if symptoms occur.

_____Administer Epinephrine (Epi-pen) 0.30cc before symptoms occur.

_____Administer Epinephrine (Epi-pen) 0.30 cc if symptoms occur.

Any child treated for anaphylaxis will be transported to the nearest Emergency Room.

_____

Physician's Signature and Date

Parent/Guardian Authorization:

I hereby request that the above medication, ordered by the physician for my child _____ be administered by authorized school personnel. I will notify any before/after school, extracurricular programs of my child's allergic condition.

Signature_____Relationship to child_____

Phone#_____

Please return to School Nurse's Office. The School Nurse may contact the physician to clarify orders.

FORM FA-2

New Canaan Public Schools

School:_____ Grade:_____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in unopened, properly labeled container.

Prescriber's Authorization

Name of student: _____ Date of Birth:_____

Address:_____

Condition for which drug is being administered:_____

Drug Name:_____ Dose:_____ Route:_____

Time of Administration: _____ If PRN, frequency:_____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (specify): _____

Medication shall be administered from: _____ (MM/DD/YYY) to _____ (MM/DD/YYY)

Prescriber's Name/Title: _____ (type or print)

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

☐ I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

☐ I have administered one dose.

Parent/Guardian Signature: _____ Date:_____

Parent's Home Phone #: _____ Work #: _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION / APPROVAL

Self-administration of medication (inhalers and EpiPens) may be authorized for middle and high school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self administration : ☐ Yes ☐ No _____ Signature

Prescriber's authorization for self-carry: ☐ Yes ☐ No _____ Signature

Parent/Guardian authorization for self administration ☐ Yes ☐ No _____ Signature

School nurse approval for self administration ☐ Yes ☐ No _____ Signature

Received by: _____ Date of receipt:_____