TOWN OF FAIRFIELD HEALTH PROGRAM MEDICATION AUTHORIZATION FOR STUDENT WITH SEVERE ALLERGIC REACTION (FOOD, INSECT, LATEX, ENVIRONMENTAL, OTHER)

| Name of Stud | dentDate of Birth |
|---------------|--|
| Specific Alle | ergen |
| P | lease prescribe two auto-injectors for child to have in school if repeat dose is ordered. |
| A. Epipen | Administration (CHOOSE EITHER #1 or #2) |
| 1. Administ | ter epinephrine immediately if child knowingly and/or suspects he/she was exposed to |
| | one: □ Epinephrine 0.3mg IM or SC □ Epinephrine 0.15mg IM or SC Epipen Auto-Injector □ Epipen Jr. Auto-Injector |
| b. Side-e | ffect/plan for management |
| a. Check | ster epinephrine if symptoms of anaphylaxis occur. c one: Epinephrine 0.3mg IM or SC Epipen Auto-Injector Epipen Jr. Auto-Injector |
| b. Side-e | effects/plan for management |
| 1. I 2. I | Drug name (Brand and Generic) Dose Route |
| 4. 1 | Frequency |
| 5. 7 | Administer (check one) immediately following administration of epinephrine (see above). at the time of actual exposure or suspected exposure to allergen in the absence of symptoms. Continue to observe for symptoms of anaphylaxis. for non-threatening allergic reaction i.e., rash. Continue to observe for symptoms of anaphylaxis. |
| Side | e-effects/plan for management |
| Studen | ats may self-administer medications(s)EpipenAntihistamine. |
| | Self-administration means that the student will carry and administer his/her medication(s) without assistance. |
| Duration of | Order(s): fromto(date) |
| | M.D./D.O./D.D.S./A.P.R.N./P.A./O.D. |
| Signature | Date |
| Address | Telephone Fax |

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM AUTHORIZATION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

| Name of Student | Date o | of Birth | las-1 |
|---|---|-------------------------------------|----------------------------|
| School | Grade | | y Turkyy i d |
| Medication | 3 - 221 | | |
| I hereby give my permissic authorized prescriber. | on for my child to receive the above medic | ation in school as ordered by hi | is/her physician or other |
| Self-administration of me | dication means that the student will carry and | administer his/her medication with | nout assistance. |
| Student may self-administer | the above medication: (circle one): Yes No | | |
| I give my permission for corthis medication order in scho | mmunication between the school nurse and pre | scriber of this medication as neede | ed for implementation of |
| I authorize that this medicat by dismissal on the last day | tion be destroyed if it is not picked up within of school, whichever comes first. | one week following termination of | of the medication order of |
| | | | |
| Date | Signature of Parent or Guardian | Telephone | |
| | | | |
| _ | Print Name of Parent or Guardian | | |
| Rev. 1-11, 9-11 | | | |

Rev. 1-11, 9-11 SHM Vol. II, Sec. 3, Medications/Spec.Hlth.Care Needs