Saint Catherine of Siena School
Health Office

EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

ALLERGY TO:____

Student's Name:______________________________ D.O.B:____________ Teacher__________________

Asthmatic Yes ☐ * No ☐ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	Symptoms:
• **MOUTH**	itching & swelling of the lips, tongue, or mouth
• **THROAT***	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
• **SKIN**	hives, itchy rash, and/or swelling about the face or extremities
• **GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
• **LUNG***	shortness of breath, repetitive coughing, and/or wheezing
• **HEART***	"thread" pulse, "passing-out"

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

ACTION:

1. If ingestion is suspected, give ____
   Medication/dose/route
   and ____ immediately!
2. CALL RESCUE SQUAD:____
3. CALL: Mother __________________ Father: __________________ or emergency contacts.
4. CALL: Dr: ______________________________ at ______________________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

________________________ ____________ ________________________M.D. ____________
Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. ______________________________	1. ______________________ Room _________
Relation:______________ Phone:______________	
2. ______________________________	2. ______________________ Room _________
Relation:______________ Phone:______________	
3. ______________________________	3. ______________________ Room _________
Relation:______________ Phone:______________	

Saint Catherine of Siena School
Health Office
249 Nahatan Street
Norwood, MA 02062
Phone / Fax: (781) 769-5455

Dear Parents / Guardians,

All children have a right to confidentiality especially when it involves their health records. Because of this right, we are not allowed to share pertinent medical information with our staff without **written** permission from a parent or guardian. We are trying to get our records and permission slips ready for the fall.

If you could, please take a moment and fill out the form for your child ______________________________ and return it to school as soon as possible. The sooner we receive this information, the sooner we can inform our staff. (Of course, this is done only on a need to know basis.) If you have any questions or problems regarding this issue, please don't hesitate to call me at (781) 769-5354 extension 232 or (781) 769-5455.

Please remember that without this permission, no information regarding your child's health can be released. Thank you for your cooperation.

Lisa Igoe, RN

School Nurse

I,____ give my permission for the school nurse to share pertinent medical information about my child, _________________________
first and last name
with his/her teachers and/or other school personnel that she determines should need to know this condition.

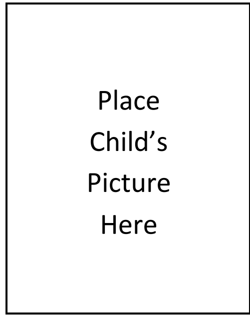
****

I,____ **do not give** permission for the school nurse to share pertinent medical information about my child, ______________________________.
first and last name

Date:__________________________

Saint Catherine of Siena School
Health Office

INFORMATION CARD



STUDENT'S NAME:____

TEACHER'S NAME:____

GRADE:____________________ ROOM:____________________

FOOD ALLERGIES:____

FOODS THAT CANNOT BE EATEN:_____________________________________

____

____

____

____

____

______________________________ ______________________

Parent's Signature Date

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Medication Order Form for Physician and Parent

To be completed by Physician:

It is necessary that the following medication be given during the school hours: Yes___ No____

Name of Student:____ D.O.B.:_____________

Medication:____

Dosage/Route/Frequency/Time:____

Start Date:________________________ Stop Date:________________________

Special Instructions/Possible Side Effects/Known Allergies:____
____

*Diagnosis (if not confidential): ____

_______________________________________ _________________________________

Physician's Signature Date

____ _________________________________

Address Telephone

To be completed by the Parent/Guardian:

Student's Name: (print)___________________________ DOB:_______________ Grade:_____

Your Telephone: (home)___________________________ Cell/Work:________________________

1. I give permission for the school nurse or her designee to administer the above named medication as prescribed.
2. This medication is being taken for:____
3. List any other medication your child takes:____
4. Physician's name: (please print)____
5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.

   Yes:_________ No:__________

Please note: I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following termination of the order.

Signature of Parent/Guardian:____________________________ _________________________________

Please print Parent/Guardian Name

Date:____________________________

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Medication Order Form for Physician and Parent

To be completed by Physician:

It is necessary that the following medication be given during the school hours: Yes___ No____

Name of Student:____ D.O.B.:_____________

Medication:____

Dosage/Route/Frequency/Time:____

Start Date:_________________________ Stop Date:_________________________

Special Instructions/Possible Side Effects/Known Allergies:___________________________________
____

*Diagnosis (if not confidential): ____

____ ___________________________________

Physician's Signature Date

____ ___________________________________

Address Telephone

To be completed by the Parent/Guardian:

Student's Name: (print)____________________________ DOB:_______________ Grade:_____

Your Telephone: (home)___________________________ Cell/Work:_________________________

1. I give permission for the school nurse or her designee to administer the above named medication as prescribed.
2. This medication is being taken for:____
3. List any other medication your child takes:____
4. Physician's name: (please print)____
5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.

   Yes:__________ No:__________

Please note: I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following termination of the order.

Signature of Parent/Guardian:_____________________________ ___________________________________

Please print Parent/Guardian Name

Date:______________________________

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PARENT/GUARDIAN PERMISSION FOR THE ADMINISTRATION OF MEDICATION

Name of Student:_________________________ D.O.B.:_____________

School:_________________________ Grade:_____________

Name of Parent/Guardian:_________________________

Please Print

Address:_________________________

Telephone Number: (Home)_______________(Work)_______________

Known Allergies:_________________________

Other Medication your child takes:_________________________

CONSENT

1. I give permission to the school nurse or her designee to administer the following:

   _______________________ _______________

   Medication *Dose*

   Measured as:_________________________

   Quantity (Teaspoon, tablet, puffs, etc.)

   Approximate time:_____________

   Specific instructions:_________________________

   Start Date:_______________ Stop Date:_______________

2. This medication is being taken for:_________________________

   Reason

   Physician's name:_________________________

3. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.

   Yes:__________ No:__________

   Any restrictions on release:_________________________

   (*Please note: I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following termination of the order.)*

   Signature of Parent/Guardian:_________________________

   Date:_______________