# PETERS TOWNSHIP SCHOOL DISTRICT MEDICATION ADMINISTRATION CONSENT AND EMERGENCY CARE PLAN FORM FOR STUDENTS WITH FOOD ALLERGIES

**This form is to be completed by student's physician or healthcare provider, in cooperation with student's parents/guardians and submitted prior to enrollment in the District at the beginning of each school year or immediately after diagnosis of any condition or allergy. The form must be signed by both the parent/guardian and student's physician or healthcare provider.**

Student's Name:_____ Date of Birth :_____
School Name:_____ Grade/Room/Section:_____
Physician Name:_____ Phone:_____
Preferred Hospital:_____
Emergency Contact:_____ Phone: _____
Emergency Contact:_____ Phone: _____

## SECTION 1: EMERGENCY CARE PLAN FOR A STUDENT WITH FOOD OR OTHER SEVERE ALLERGIES

Student has an allergy to:_____
Does the student also have asthma? **[ ] Yes (higher risk for a severe reaction) [ ] No**
**Student is extremely reactive to the following allergens: _____**
_____

**COMMON SIGNS OF AN ALLERGIC REACTION** (This is not an exclusive list of symptoms)
MOUTH: Itching, tingling, swelling of the lips, tongue, or mouth
THROAT: Itching and/or a sense of tightness in the throat, hoarseness, hacking cough
SKIN: Hives, itchy rash, swelling about the face or extremities
GI: Nausea, vomiting, abdominal cramps, diarrhea
LUNGS: Shortness of breath, repetitive coughing, wheezing
HEART: "Thready" pulse, dizziness or fainting

DURING AN ALLERGIC REACTION, HIS/HER TYPICAL SYMPTOMS ARE:
_____
_____

NOTE: Different symptoms may occur with any reaction and severity of symptoms can change rapidly. A high level of suspicion needs to be maintained for any symptoms exhibited by a student with food allergies.

****PHYSICIAN TO COMPLETE THIS SECTION****

IF INGESTION IS SUSPECTED AND/OR SYMPTOMS ARE PRESENT, **IMMEDIATELY** DO THE FOLLOWING:

1. TREATMENT
   - **[ ] If checked, give Benadryl immediately. If reaction persists, follow up with use of epinephrine immediately.**
   - **[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**
   - **[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**
2. CALL 911
3. CONTACT PARENT/GUARDIAN/DESIGNEE

**STUDENT NAME: _____ Grade_____**

**Authorization to receive medication in school:**

I fully understand the directions that have been given to the school by the physician and I give my consent for the medication prescribed below by the physician to be administered to my child at school or for the school to monitor the self-administration of the medication by my child. In consideration of the School District's agreement to use good faith efforts to follow the physician's instructions, I hereby release the School District and its personnel from any liability associated with the administration of this medication either by School District personnel or by my child.

I understand and agree that any medical information may be shared with appropriate school and medical personnel. I authorize necessary school personnel to contact the medical provider named above regarding this medication and to release information regarding my child (named above) to that provider. I authorize the medical provider to release information to the school regarding my child (named above) and his/her medication(s). I understand that this consent is necessary in order to protect the limited confidentiality of medical information and that this consent is limited for the purpose and to the person or entity listed above and will be effective for the present school year. I understand that the disclosed information will be kept confidential and that disclosing school personnel will not be responsible for the re-disclosure of any such information.

I understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

**X PARENT/GUARDIAN SIGNATURE:_____ Date_____**

**PRINT PARENT NAME:_____**

****PHYSICIAN TO COMPLETE THIS SECTION****

| **To be given during school:** | **Medication #1** | **Medication #2** | **Medication #3** |
|---|---|---|---|
| Name of Medication:<br>Dose/Route: | Epi-Pen<br><br>☐ Not Applicable | Benadryl<br><br>☐ Not Applicable | _____ Inhaler<br><br>☐ Not Applicable |
| Indication/Reason to be given: | | | |
| Time/frequency to be given: | | | |
| Date to be initiated: | | | |
| Date to be discontinued: | | | |
| Special Instructions:(e.g. activity restrictions, precautions, etc.) | | | |
| Possible Adverse reactions: | | | |

***Please circle*: INHALERS & EPINEPHRINE AUTO-INJECTORS *ONLY*:**

This student is capable of self-administration: Yes___ No___

This student may carry his/her inhaler or epinephrine auto-injector on his/her person: Yes___ No___

Comments: _____

_____

**PHYSICIAN SIGNATURE: _____Date_____**

**PRINT PHYSICIAN NAME: _____ Date_____**

********Anytime there are medication changes, this form must be updated by the parent/physician.*

## SECTION 2: STUDENT WITH A DISABLING* DIETARY NEED

****PHYSICIAN TO COMPLETE THIS SECTION****

☐ _____ has a dietary disability (Please complete questions 1-5 below)
STUDENT NAME

☐ _____ does **NOT** have a dietary disability (Please complete *** section below)
STUDENT NAME

***Only a physician can declare if a student has a disability. For purposes of a disability dietary need, examples of a disability may include metabolic conditions (e.g., diabetes), severe food allergies or cerebral palsy.**

1. Explain the student's special dietary disability:_____
   _____
   _____
2. State why the dietary disability restricts the student's diet: _____
   _____
   _____
3. What major life activities are affected by this disability? _____
   _____
   _____
4. What foods should be restricted or omitted from the student's diet? _____
   _____
   _____
5. What foods can be provided as a substitute? _____
   _____
   _____

If the student does not have a disabling dietary need, but rather, has a special dietary need* that you would like the District to consider accommodating, please provide the following:

*Examples of special dietary needs may include food intolerances or allergies that do not cause life-threatening reactions.

1. Explain the student's special dietary condition:_____
   _____
   _____
2. What foods would you like to be omitted from the student's diet? _____
   _____
   _____
3. What foods can be provided as a substitute? _____
   _____
   _____

**PHYSICIAN SIGNATURE: _____Date_____**

**PRINT PHYSICIAN NAME: _____ Date_____**