Dear Parent/Guardian

In an effort to have our health records complete, we request that this update be completed for this school year. If there are any issues you wish to discuss please contact us at any time through a note or a phone call to your child’s school. Thank you for your cooperation.

Wakefield School Nurses

STUDENT NAME ________________________________

SCHOOL ___________________ GRADE & TEACHER ________________________________

1. Allergies- (food, insect bites, medications, etc.)
   □ NONE KNOWN
   □ Allergy requiring medication in school: _____________________________________________
      
      Medication: ___________________________________________________________________

   *If student will need any medication at school an Allergy Action Plan signed by the MD and parent must be provided along with the medication

   □ Allergies/Sensitivities NOT requiring medication in school: __________________________
      
      Treatment at home if applicable __________________________________________________

2. Medical Conditions- (heart problems, seizures, diabetes, etc.)
   □ NONE KNOWN
   □ YES Condition: ____________________________

3. Asthma
   □ NONE KNOWN
   □ YES (Please fill out ASTHMA CARE PLAN on back)

4. Is your child on medication?
   □ NO
   □ YES *Medication and reason: ________________________________

   *Medication cannot be administered in school unless it is brought in by an adult, with a note from the parent/guardian, in the ORIGINAL CONTAINER, and we have a PHYSICIAN’S ORDER. (Rx. label on the bottle is sufficient for up to 10 days administration.) Students may NOT self medicate except under a few specific conditions. ANY over the counter medication (except Tylenol/Advil in GRADES 5 OR HIGHER) require an MD order (i.e. cough syrup, Benadryl)

5. Glasses:
   □ NO
   □ YES Distance □ Reading □

6. Hearing: Any known loss or problems? ________________________________

7. Insurance Co. ________________________________ None □

8. Any additional information you feel it is important for us to know? ________________________________

9. I give permission to share PERTINENT INFORMATION about my child’s health condition with teachers, paraprofessional, cafeteria workers, bus drivers and field trip chaperones as deemed APPLICABLE by the school nurse

__________________________________________________________

Parent/Guardian Signature

Received and checked ________________________________

Should you need this information translated, please contact the principal of your child's school.

En caso de necesitar esta información traducida, por favor comuníquese con el director de la escuela de su hijo.

Se você precisar de informações traduzido, por favor, entre em contato com o diretor da escola do seu filho.
ASTHMA ACTION PLAN

☐ My Child has NO current problem with Asthma. Parent Signature: __________________________ Date: ______

☐ My Child has symptomatic occurrences of Asthma. (Please complete below)

If your child has symptomatic asthma, please supply the following information

Physician Treating Student for Asthma: __________________________ Phone: __________________________

Other Physician: __________________________ Phone: __________________________

Daily Asthma Management Plan

Identify the things that start an asthma episode (check each that applies to the student)

- Exercise
- Strong odors or fumes
- Respiratory infections
- Chalk dust/dust
- Change in temperature
- Carpets in the room
- Animals
- Pollen
- Food
- Molds

Other (describe) __________________________________________

Does your child take asthma medications ☐ Daily ☐ ONLY when having an asthma attack

List daily medications (if applicable): __________________________________________________________

Describe your child’s asthma symptoms: ______________________________________________________

Does your child understand asthma and his/her management of asthma?  ☐ Yes  ☐ No

If no, describe what he/she still needs to learn. __________________________________________________

Asthma Medication Plan in School

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
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<tbody>
<tr>
<td>1.</td>
<td>__________________________</td>
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<tr>
<td>2.</td>
<td>__________________________</td>
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Inhalers at School

If your child’s plan includes the use of an inhaler, please choose one.

☐ The student comes to the nurse’s office where the inhaler is kept unlocked and uses it under the nurse’s supervision. The advantage is that the medication will be used correctly under supervision.

☐ QUALIFIED students will be allowed to carry their inhaler. The advantage is immediate accessibility. It is recommended a spare inhaler kept in the nurse’s office in case the student should forget theirs or run out. If my child carries an inhaler with them at school:
  • The student agrees never to share the inhaler with another student
  • The student agrees that after two puffs, if there is not marked improvement they will go to the nurses office immediately.
  • THE INHALER IS PROPERLY LABELED WITH THE CHILD’S NAME AND THE PRESCRIPTION LABEL IS ATTACHED

Parent Signature: __________________________ Date: __________________________

Date received and checked __________________________
WAKEFIELD PUBLIC SCHOOLS
ALLERGY EMERGENCY CARE PLAN / INDIVIDUALIZED HEALTH CARE PLAN

Name: [ ]
Date: [ ]

Birth Date: [ ]
Grade/Teacher: [ ]

School: [ ]

Asthmatic? [ ] yes [ ] no

Prior history of Anaphylaxis? [ ] yes [ ] no

*if yes, increased risk for severe reaction

Severe Allergy to: [ ]

ACTION PLAN

ANY SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

**LUNG:** Short of breath, wheeze, repetitive cough

**HEART:** Pale, blue, faint, weak pulse, dizzy, confused

**THROAT:** Tight, hoarse, trouble breathing/swallowing

**MOUTH:** Obstructive swelling (tongue or lips)

**Skin:** Many hives over body

OR combination of symptoms from different body areas:

**SKIN:** Hives, itchy rashes, swelling (e.g. eyes, lips)

**GUT:** Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY.** (see reverse side for directions)
2. Call 911
3. Stay with and monitor student
4. Give additional medications*
   - Antihistamine
   - Inhaler (bronchodilator) if asthmatic

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis) USE EPINEPHRINE

MILD SYMPTOMS ONLY:

**MOUTH:** Itchy mouth

**SKIN:** A few hives around mouth/face, mild itch

**GUT:** Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE** (if ordered. Must be given by nurse.)
2. Stay with student and monitor
3. Alert healthcare professionals and parent
4. IF symptoms progress (see above) USE EPINEPHRINE

MEDICATION ORDERS (must be filled out by licensed health care provider)

<table>
<thead>
<tr>
<th>EpiPen® only</th>
<th>EpiPen® and antihistamine</th>
<th>* (complete dosage information below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] EpiPen® (0.3)</td>
<td>[ ] EpiPen Jr® (0.15)</td>
<td>Side effects: tremors, dizziness, rapid pulse, nausea, vomiting</td>
</tr>
<tr>
<td>Antihistamine:</td>
<td></td>
<td>Side Effects: drowsiness, dizziness</td>
</tr>
</tbody>
</table>

In grades 5 – 12 student may carry and self-administer his/her EpiPen®

[ ] yes [ ] no

Licensed Health Care Provider’s Signature: [ ]
Date: [ ]

Photo Required

The School Nurse will insert a photo if none is provided.

11/30/13
**EMERGENCY CONTACT NUMBERS (to be completed by parent/guardian)**

<table>
<thead>
<tr>
<th>Parent/ Guardian:</th>
<th>Home phone:</th>
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<table>
<thead>
<tr>
<th>Emergency contact:</th>
<th>Phone:</th>
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<tr>
<td>Relationship:</td>
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<table>
<thead>
<tr>
<th>Primary Care Physician:</th>
<th>Phone:</th>
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<tr>
<th>School Nurse:</th>
<th>Phone:</th>
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<tr>
<th>Other health concerns:</th>
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<tr>
<td>Other medications:</td>
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</table>

| Dietary concerns/restrictions: |
| I give permission to share pertinent information about my child’s health condition with staff, lunchroom volunteers, and field trip chaperones as deemed necessary by the School Nurse. |

| Parent signature: | Date: |

**INDIVIDUAL CONSIDERATIONS**

**Bus Transportation**
- Parent should alert transportation staff to student’s allergy at the time of application.

**Field Trip Procedures**
- EpiPen® and Emergency Care Plan should accompany student during any off campus activity.
- In grades Pre-K – 4 the student should remain with EpiPen®-trained designated staff or parent/guardian during the entire field trip.

**Classroom**
- This student will be allowed to eat only the foods approved by parent.
- Classroom projects should be reviewed by teaching staff to avoid specific allergens.
- Teachers, substitute teachers and specialists will be informed of the life-threatening food allergy.
- The use of food during classroom celebrations/instruction is restricted per WPS Allergy Policy (GP-020-03).

**Cafeteria**
- Nutrition services staff should be alerted to the student’s allergy by the School Nurse.
- Parent will be responsible to contact Nutrition Services to obtain ingredient lists for any food purchased.
- In accordance with WPS Allergy Policy (GP-020-03) a “no food sharing” practice will be implemented in school.

**Under M.G.L. c.94Cand DPH Regulations105 CMR 210.000**

The School Nurse may train unlicensed personnel to administer epinephrine by auto-injector to individuals with a diagnosed allergic condition in a life-threatening situation during the school day when a school nurse is not immediately available, including field trips.

PLEASE NOTE: Staff members are not permitted to administer Benadryl (antihistamine). In the absence of the School Nurse, the staff member will administer epinephrine by auto-injector and call 911.

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