FIELD TRIP
EMERGENCY PLAN OF CARE

Name: _____ **School:** _____

Allergy: _____ **School Year:** _____

SYMPTOMS OF ANAPHYLAXIS:

- Chest tightness, shortness of breath, cough , wheezing, profuse runny nose
- Dizzy, faint, pale, blue, confused
- Tightness and / or itching in throat, difficulty swallowing, hoarseness, drooling
- Swelling of lips, tongue, throat
- Itchy mouth, itchy skin, hives
- Hives, itching (anywhere), swelling (e. face, eyes)
- Nausea, vomiting, diarrhea, crampy pain

Insert Picture If Available

IF ALLERGEN LIKELY EATEN (OR STUDENT STUNG), FOLLOW THIS EPINEPHRINE PROTOCOL AT THE ONSET OF ANY OF THE ABOVE SYMPTOMS:

1. Administer Epi Auto-Injector: _____**0.15mg** _____**0.3mg**
2. Have someone call 911 for ambulance, don't hang up, and stay with student
3. Have student lie down with feet above level of head until EMS arrives.
4. Notify school and parent /guardian as soon as possible.

EMERGENCY CONTACTS

1. Name: _____
   Relation: _____
   Phone: _____

2. Name: _____
   Relation: _____
   Phone: _____

EMERGENCY / PHYSICIAN CONTACTS

1. Name: _____
   Relation: _____
   Phone: _____

2. Name: _____
   Relation: _____
   Phone: _____

_____ **Parent / Date**

_____ **Student if applicable / Date**

_____ **School Nurse / Date**

_____ **Physician**

_____ **Date**

FOOD / INSECT ALLERGY EMERGENCY PLAN OF CARE DURING SCHOOL

School _____ **School Year** _____

STUDENT INFORMATION

Student Name:	**DOB:**
Home / Cell Phone:	**Grade:**
Life-Threatening Allergies:	**History of Asthma?** ☐ **No** ☐ **Yes** **(Asthma may indicate an increased risk of sever reaction)**
	Severe Anaphylactic Reaction? ☐ **No** ☐ **Yes** **Dates of Anaphylactic Reaction:** _____ ☐ If checked **YES**, give Epinephrine immediately if allergen was likely eaten, at onset of **any** symptoms, and follow the protocol below.

TREATMENT PLAN

ANY SEVERE SYMPTOMS (Anaphylaxis) AFTER SUSPECTED OR KNOWN INGESTION: / CONTACT **ONE OR MORE** OF THE FOLLOWING: **LUNG:** Short of breath, chest tightness, wheeze, repetitive cough **HEART:** Pale, blue, faint, weak pulse, dizzy /confused **THROAT:** Tight, hoarse, trouble breathing / swallowing, drooling **MOUTH:** Obstructive swelling (tongue or lips) OR COMBINATION OF SYMPTOMS FROM *DIFERENT BODY AREAS*: **SKIN:** Hives, itchy rashes, swelling (e.g. eyes, lips) **GUT:** Nausea, Vomiting, diarrhea, crampy pain	⇨	FOLLOW THIS PROTOCOL: 1. INJECT EPINEPHRINE IMMEDIATELY! 2. Call 911 3. Raise feet above the head, remain lying down and continue monitoring. 4. Give additional medications as ordered - Antihistamine - Bronchodilator/Albuterol if has asthma 5. Notify Parent/Guardian 6. Notify Prescribing Provider / PCP 7. When indicated, assist student to rise slowly
ORAL ALLERGY SYNDROME OR MILD SYMPTOMS: **MOUTH:** Itchy mouth, lips, tongue and/or throat SKIN: Itching just around mouth GUT: Mild Nausea, Vomiting, diarrhea, crampy pain	⇨	1. **GIVE ANTIHISTAMINE (swish and swallow if liquid)** 2. Monitor student as indicate; notify healthcare provider and parent as indicated. 3. If progresses to symptoms of **anaphylaxis**, USE EPINEPHRINE (as stated above)

_____ _____

Physician Name / Telephone Physician's Signature

_____ _____

Guardian Name / Telephone Guardian Signature

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ___/___/___ End Date ___/___/___

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ___/___/___

Parent /Guardian's Address _____Town_____State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____ Signature _____ Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____ Signature _____ Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____ Signature _____ Date

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ___/___/___ End Date ___/___/___

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/_____ End Date: ____/____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ___/___/___

Parent /Guardian's Address _____Town_____State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)