STUDENT HEALTH HISTORY - ALLERGY

Student Name: _____ Student Number: _____

Date of Birth: _____ School: _____ Teacher/Grade: _____

Doctor: _____ Doctor's Number: _____ Ride Bus: Yes__ No__

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Allergy/Allergies: _____

Year diagnosed with allergy: _____ Date of most recent reaction: _____

Has your child been prescribed emergency epinephrine (Epi-Pen)? ___Yes ___ No

- If yes, has it been necessary for your child to receive the emergency injection? ___ Yes ___ No
- When? _____ How many times has an emergency injection been needed? _____

Signs of an allergic reaction in my child may include: (*please check all boxes below that may apply.)*

- ☐ **Mouth**- itching and swelling of lips, tongue or mouth
- ☐ **Throat-** itching and/or tightness; hoarseness, hacking cough
- ☐ **Skin**- hives, itchy rash, and/or swelling of the face or extremities, pale, clammy
- ☐ **GI-** nausea, abdominal cramps, vomiting, and/or diarrhea
- ☐ **Lungs**- shortness of breath, repetitive cough, and/or wheezing
- ☐ **Heart-** thready, weak pulse, loss of consciousness, pale
- ☐ **Other** _____

Does your child take any allergy medications at home? ___ Yes ___ No If yes, please list:

Medication	Dose	How often
1.		
2.		

*Please complete and sign reverse

STUDENT HEALTH HISTORY - ALLERGY

Does your child require emergency medications be kept at school in the event of an allergic reaction?
___ Yes __ No

If yes, list the emergency medications below:

District Medication Authorization forms must be completed and signed by parents and the prescribing physician and be on file at the school before any medications may be administered. Parent must bring medications to school

Medication	Dose	Describe When to Use
1.		
2.		

Do you request that your child sit at a peanut or other allergen-free table? ___ Yes ___ No
Please contact the school nurse to discuss other requested accommodations.

EMERGENCY PLANS:

- In the event of a lockdown, medication kept in the clinic will not be available to your child. We encourage you to discuss a plan with your child's physician and the school nurse. Please note any special instructions to be included as part of your child's Emergency Action Plan below.

  _____

- In the event of an evacuation, emergency medications will be taken to the evacuation site, whenever possible.

I understand that my child's Emergency Action Plan will be shared with appropriate school staff that have a need to know about the health condition. I further understand that the school is not responsible for damage or loss of equipment utilized in providing medically prescribed treatments or procedures.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information provided on this Health History form.

Parent/Guardian: _____ _____
Signature Date

Reviewed by: _____ _____
School Nurse Date

****

FOR SCHOOL NURSE USE ONLY

Notes: _____

_____

_____

Student Name_____ # _____

Collier County Public Schools
Medication Authorization Form

Student's Name: _____ Sex: M ☐ F ☐ Date of Birth: _____ Student #: _____

School Name:_____Grade:_____Teacher: _____

Allergies: _____

MEDICATION INFORMATION

Medical Condition for which medication will be required for student in school: _____

ICD10 Code _____

Name of Medication: Prescription _____ Over-the-Counter _____

Route to administer (*please check one)* ☐ Oral (BY MOUTH) ☐ Topical (ON THE SKIN) ☐ Subcutaneous (INJECTED) ☐ Inhaled (BREATHED) ☐ IM Other _____

Dosage: _____ Frequency:_____ Time of Day: (ex.11:00 AM) _____

Is this a new medication? ☐ Yes ☐ No If yes, the first dose must be administered at home.

Special Instructions: _____

Prescription medications require healthcare provider signature below:
Physician's orders are required for <u>all prescription medications given at school</u>

Physician's Name (Print): _____ Phone Number: _____

Physician's Signature: _____ Date: _____ Fax Number: _____

☐ I have prescribed the student to self-carry MDI, pancreatic enzymes, EPI-PEN, or other life saving medications described on this page.

PARENT/GUARDIAN AUTHORIZATION

1. I give permission for my child's doctor to be contacted for information regarding the administration of the medication listed on this form.
2. I authorize the above medication to be administered as described or prescribed during school or after-school programs operated by Collier County Public Schools.
3. I understand that medication not picked up by the last day of school will be discarded.
4. I understand that medication may not be administered if either the "discard after date" or the manufacturer's expiration date has passed.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

Home phone: _____ Business phone: _____Emergency phone number: _____

FOR SCHOOL NURSE USE ONLY.

☐ Physician's Verbal Order Obtained: Date: _____ Time:_____ Received From: _____

Content of physician's verbal order obtained: _____

Reviewed by: _____ Date: _____
School Nurse

Please see reverse side of this document for Medication Authorization Information

Collier County Public Schools Medication Authorization Form

Dear Parent/Legal Guardian:

If your child requires medication(s) during the school day, Florida Statutes and School Board Policy require that you provide written authorization for all medications to be given. An authorization for prescription medication must also be completed and signed by a physician or other health care provider licensed in the state of Florida (as outlined in Florida Statutes, F.S. 464) ***(Medications not approved by the Food and Drug Administration (FDA) and alternative medications, including natural, herbal remedies, homeopathic medicines, food supplements, and vitamins may not be administered at school, with the exception of prescribed pancreatic enzymes or prescribed dietary products to treat lactose intolerance)***

- The Medication Authorization Form on the reverse side of this document must be entirely completed and accompany prescribed or over-the-counter medications to be given to your child in school. The form must be signed by a parent/legal guardian. The prescribing healthcare-provider must also complete and sign the form for any **prescription** medications to be given. **Medications will not be administered without a completed Medication Authorization Form.**

- A parent/legal guardian or an authorized adult must deliver medications to the school health room. At the time of delivery, the quantity of each medication will be verified by the school nurse or school personnel. **Do not send medications to school with your child**.

- Medications given only one time per day or medications that can be given before or after school are not administered at school.

- Prescription medications must be received at school in a container with the original, unaltered prescription label attached. The l**abel must be written in English and** display all information required by law, including, but not limited to: date of prescription, "discard after date," student's name, medication name, dosage, time to be administered, and the prescribing healthcare-provider's name.

- Medication may not be administered at school if either the "discard after date" **or** the manufacturer's expiration date has passed.

- Over-the-counter (OTC) and FDA approved non-prescription medications must be in the original sealed (unopened) store-issued container. Please label the container with your child's full name and birth date. OTC medications, including cough drops, will only be given according to directions on the label. If a parent/guardian requests dosages that do not appear on the non-prescription medication label, orders stating the reason for the administration variation must be obtained from the healthcare-provider by the parent/guardian and will be considered by a school nurse before administration may occur. **Based on the school nurse's assessment, a parent may be required to obtain a physician's authorization for increased and/or daily administration of a non-prescription medication.**

- If your child is authorized to self-carry and use life saving medications as prescribed by his/her healthcare-provider, the child must demonstrate competency in self-administration/self-treatment and a "Contract for Self-Carried Medication" must also be completed and signed by the parent and school nurse. **Medication with current prescription label must be signed-in to school clinic.**

Please see reverse side of this document for Medication Authorization