REGIONAL SCHOOL DISTRICT #16
BEACON FALLS and PROSPECT

HEALTH REQUIREMENTS

In order to be admitted into the school setting, please be sure that you have the necessary paper work and all immunizations are up to date. Please review the immunizations required on the attached form.

A copy of your child's immunization record must be on file on or prior to the first day of school, so that the school nurse can be sure that all immunizations are up to date.

A physical exam is required for all students entering kindergarten, by the end of 7th grade and by the end of 10th grade. Please be sure that your physician completes all the starred (*) items, including vision, hearing and the required blood work. This is mandated by Connecticut State Statutes.

All children entering Region #16 from out of state are required to submit a physical that has been done within the past year, i.e. if you are entering in the month of September the physical can be from September of the previous year. Doctor's orders for medication from another state will not be accepted.

Children transferring from another Connecticut school system are not required to submit a physical, unless they are entering into a grade that requires a physical. This physical should be completed before entering school.

Children entering from out of the country must have proof of immunizations, a recent physical done in the United States and proof of Tuberculin testing if coming from a high risk country.

If your child is going to need medication during the school day, there are specific forms that need to be signed by you and your child's health care provider. Region #16 requires Physicians orders for both prescription and non-prescription (i.e. Tylenol, cough drops, lozenges or any over the counter medication). Connecticut State Statutes prohibit children in grades PK-8 from carrying medications to school whether it is prescription or non-prescription. Parents must bring any medications to school nurse. Students in grades 9-12 may carry medication if they have a self-carry order on file in the nurse's office.

Please contact the nurse at your child's school if there are any health-related issues that she should be aware of, or if you have any medical concerns.

Regional School District No. 16
Beacon Falls/Prospect Connecticut

Authorization for Epinephrine/Benadryl Administration by School Personnel or Self-Administration

Connecticut State Law requires a written order from an authorized prescriber (*MD, DDS, OD, DO, PA, APRN*) and parent/legal guardian/eligible student (18 years old or emancipated minor) authorization for both prescription and non-prescription medications. All medications shall be delivered to the school by the parent, guardian, eligible student or other responsible adult. The medication must be stored in the original labeled container as dispensed from the pharmacy.

Name of Student: ____ DOB: ______________________ Grade: ________

Known Allergies: ____

If student ingests or thinks he/she has ingested the above named food or has been stung by above named insect: _______________

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Please **note** desired order(s) by number : **Circle desired epinephrine injector dosage**:

____________ Observe patient for symptoms of anaphylaxis***

____________ Administer Benadryl ______ tsp. Swish and swallow

____________ Administer epinephrine ***before*** symptoms occur - **EpiPen/____________ 0.15 mg. 0.3 mg**

____________ Administer epinephrine ***if*** symptoms occur - **EpiPen/ ____________ 0.15 mg. 0.3 mg**

____________ Administer ____

9-1-1 will be called for anyone with anaphylactic symptoms or EpiPen administration.

***Symptoms of Anaphylaxis may include: Chest tightness, cough, shortness of breath, wheezing, tightness in throat, difficulty swallowing, hoarseness, swelling of lips, tongue or throat, itching mouth or skin, hives or swelling, stomach cramps, vomiting or diarrhea, dizziness or fainting.

Side Effects and Management: ____

Special Instructions: ____

Student is capable of self-administration of EpiPen (Circle One): Yes No (If "*yes*", prescriber training is required.)

Student has been trained in self-administration of this medication in prescriber's office(Circle One): Yes No

Dates of Administration: From: __________ To: _____________

Signature: ______________________________________ **(Physician / Authorized Prescriber) Date: _____________**

Address: ____ Phone: ___________________________

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Parent / Legal Guardian or Eligible Student Authorization

I hereby give permission for qualified personnel to administer/my child to self-administer/the medication above as ordered by his or her authorized prescriber. I understand that if my child is authorized for self-administration any misuse of this medication will result in disciplinary consequences following Regional School District No.16 Board of Education policy and procedure. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.

I give permission for the release and exchange of information between the school nurse and authorized prescriber necessary to ensure the safe administration of such medication.

Signature of Parent/ Legal Guardian/Eligible Student: ____

Date: _____________ Home Phone: ______________________________ Cell Phone: ______________________________

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School Nurse Authorization

Self-administration of medication may be authorized by the prescriber and parent/legal guardian/eligible student and approved by the school nurse in accordance with Regional School District No.16 Board of Education policy/procedure.

School Nurse approval for Self-Administration: { Yes { No: ____

RN Signature: ____________________________________ Date: ____