The Greenwich Spanish School

6 Riverside Ave. #108-9 – Riverside, CT 06878 - Telephone (203) 637-8288

Dear GSS Parent:

An allergy packet is attached with an Authorization for the Administration of Medication and an Emergency Health Care Plan. Please have your child's physician complete and sign the attached forms. The forms then need to be signed by a parent/guardian. Please return this form, along with your child's medication, to The Greenwich Spanish School prior to his/her return to school.

Please verify the following:

______ The original prescription label is affixed to the medication box

______ The prescription is current

______ The medication has a safety cap

______ Non-prescription medications are clearly labeled with your child's name, date of birth and prescribed dosage.

Please scan and email the completed documents to Katie Attubato at katieattubato@yahoo.com or deliver the documents to the school. Thanks you for your prompt cooperation.

Sincerely,

Katie Attubato, Nurse Practitioner

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

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

Name of Child ______________________ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name ________________________________ Controlled Drug? ☐ YES ☐ NO

Dosage ________________ Method ______________ Time of Administration________________

Specific Instructions for Medication Administration ______________________________________

Medication Administration Start Date_____/_____/_____ Stop Date _____/_____/_____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication ____

Plan of Management for Side Effects ____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain ____

Prescriber's Name ______________________________ Phone Number (_____)_______________

Prescriber's Address ____________________________________ Town _______________

Signature ____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

☐ I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program ______________________________ Today's Date _____/_____/_____

Child's Name _____________________ Address _____________________Town____________

Name of Parent/Guardian Authorizing Administration of Medication ___________________________

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _____________________

Address __________________________ Town ____________Phone Number (_____) __________

Signature of Parent/Guardian Authorizing Administration of Medication _________________________

Name of Childcare Personnel Receiving Written Authorization and Medication _________________

Title/Position ________________ **Signature (in ink)** _________________________________

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

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

Name of Child ______________________ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name ____________________________________ Controlled Drug? ☐ YES ☐ NO

Dosage ________________ Method ______________ Time of Administration________________

Specific Instructions for Medication Administration _______________________________________

Medication Administration Start Date_____/_____/_____ Stop Date _____/_____/_____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication ____

Plan of Management for Side Effects ____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain ____

Prescriber's Name _______________________________ Phone Number (_____)_______________

Prescriber's Address ____ Town _______________

Signature ____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

☐ I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program ________________________________ Today's Date _____/_____/_____

Child's Name ______________________ Address ______________________Town____________

Name of Parent/Guardian Authorizing Administration of Medication ____________________________

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _________________________

Address __________________________ Town ____________Phone Number (_____) __________

Signature of Parent/Guardian Authorizing Administration of Medication __________________________

Name of Childcare Personnel Receiving Written Authorization and Medication __________________

Title/Position ________________ **Signature (in ink)** _________________________________

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: ____________________

Child's Name: ____________________ DOB: ________ Child Care Provider____________________

History of Asthma ☐ Yes (high risk for severe reaction) ☐ No

Signs of an allergic reaction include:

Systems	Symptoms
MOUTH	Itching & swelling of lips, tongue, or mouth
*THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
*LUNG	Shortness of breath, repetitive coughing, and/or wheezing
*HEART	"Thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

If ingestion or insect sting is seen or suspected:
(prescriber should number in order all appropriate actions)

__________ Observe child for severe symptoms
__________ Administer EpiPen® before symptoms occur
__________ Administer EpiPen® if symptoms occur
__________ Administer Benadryl® (dose)__________ or Atarax® (dose) __________
__________ Call 911 (and request a paramedic) and transport to ER if symptoms occur
__________ Call 911 (and request a paramedic) and transport to ER if EpiPen® given

Preferred hospital: ____________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!

____________________ Parent Signature ________ Date ____________________ Prescriber Signature MD/APRN/PA ________ Date

____________________ Address ________ Phone

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. ____________________	1. ____________________ Room________
Relation: __________ Phone __________	
2. ____________________	2. ____________________ Room________
Relation: __________ Phone __________	
3. ____________________	3. ____________________ Room________
Relation: __________ Phone __________	

For children with multiple allergies, use one form for each allergen