Emergency Health Care Form

**Please only complete if you have indicated on the registration form that your child has a serious medical condition, asthma, or allergies*

Student Name_____ D.O.B. _____ Weight: _____

♦ STEP 1: PHYSICIAN APPROVAL ♦

DIAGNOSIS/ALLERGY TO:

_____

Asthmatic? (circle one): Yes/No

Medication(s)

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Dosage:_____

Frequency/Time to Administer/Indications or Contraindications to Administer:

If a food allergen has been ingested or student has been stung, but *no symptoms* → ___EpiPen ___antihistamine

Itching, tingling, or swelling of lips, tongue, mouth → → → → → → ___EpiPen ___antihistamine

Hives, itchy rash, swelling of face or extremities → → → → → → ___EpiPen ___antihistamine

Nausea, abdominal cramps, vomiting, diarrhea → → → → → → → ___EpiPen ___antihistamine

Tightening of throat, hoarseness, hacking cough → → → → → → ___EpiPen ___antihistamine

Shortness of breath, repetitive coughing, wheezing → → → → → → → ___EpiPen ___antihistamine

Thready pulse, low blood pressure, fainting, pale, blueness → → → → ___EpiPen ___antihistamine

OTHER:_____ → → → → ___EpiPen ___antihistamine ____other

May the student self-administer (circle one): Yes/No

End Date, if any, for this order:_____
(If no end date is provided, the school will keep this order on file for the entire school year.)

_____ _____

Date Physician Signature

_____

Physician Name/Address/Phone

NOTE: No medication may be administered (absent a life threatening situation) unless the completed Physician Approval is on-file in the school office.

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Student Name_____ D.O.B._____ Weight_____

♦ STEP 2: EMERGENCY CALLS/PARENTAL AUTHORIZATION ♦

1. Call **911** (State that an allergic reaction has been treated, and additional epinephrine may be needed.)

2. Call:

Mother/guardian _____

(H) _____ (W)_____ (C) _____

Father/guardian _____

(H) _____ (W)_____ (C) _____

3. Call: Dr. _____ at _____

Parent/Guardian's Authorization By signing below: I hereby acknowledge that all prescription medication brought to school must be in a container appropriately labeled (including dosage) by the pharmacist or physician. All over-the-counter medications must be in their original containers with appropriate dosing information. These medications may not be shared among students and must be kept in the school office or on the student if the medication does not require refrigeration or other security measures. I further hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Beth El Congregation and Spiegel Religious School Staff, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer) the lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when lawfully prescribed or over-the-counter medication is so administered or attempted to be administered, I waive any claims I might have against Beth El Congregation, its employees and agents, arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the employees and agents of Beth El Congregation, either jointly or severally, from any and all claims, damages, causes of action or injuries, except a claim based on willful and wanton misconduct, incurred or resulting from the administration or self-administration of medication.

Parent/Guardian's Signature _____ Date _____

Address _____ Phone _____