

LONG ISLAND SCHOOL FOR THE GIFTED

165 Pidgeon Hill Road
South Huntington, NY 11746
(631) 423-3557
www.lisg.org
Carol Yilmaz, Founder
Patricia Geyer, Ed.D., Head of School

Dear Parent/Guardian:

Enclosed are medication forms in case your child may require emergency medication while in school.

Please complete the enclosed Health History form.

Have your doctor complete the following forms:

1. Food Allergy Action Plan for all medication needed
2. Medication release for each medication needed
(One form for each medication)

Please don't hesitate to call with any questions or concerns.

Sincerely,

Karen Jacobsen RN

Karen Jacobsen, RN
[kjacobson@lisg.org](mailto:kjacobsen@lisg.org)

KJ/jmo
Enclosures



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Mrs. Carol Yilmaz, Founder
Dr. Patricia Geyer, Head of School

HEALTH HISTORY

Caring for Students with Food Allergies

Student Name: _____ Date of Birth: _____ Grade: _____

Primary Health Concern: _____

Secondary Health Concern(s): _____

Healthcare Provider's Name: _____ Phone: _____

Diagnosis (note specific allergens): _____

At what age was the student diagnosed with a food allergy? _____

What symptoms led to the diagnosis? _____

Approximately how many allergic reactions has the student experienced? _____

When was his/her last allergic reaction? _____

Has the child been hospitalized as a result of an allergic reaction? Yes How many times? _____

No

Does the child have an early awareness of the onset of an allergic reaction? _____

What treatment does the child usually require for an allergic reaction? _____

Has the student experienced an allergic reaction at school before? _____

If so, please describe incident: _____

Does the student have asthma? Yes No (Asthma can increase the severity of a reaction)

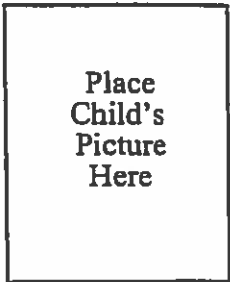
Is there anything else that the school should know to take the best care we can of your student?

All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a "need to know" basis? Yes No

Parent/Guardian Signature _____ Date _____

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat † Tightening of throat, hoarseness, hacking cough
- Lung † Shortness of breath, repetitive coughing, wheezing
- Heart † Thready pulse, low blood pressure, fainting, pale, blueness
- Other † _____
- If reaction is progressing (several of the above areas affected), give

Give Checked Medication:**

- | | |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

To be determined by physician authorizing treatment

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____

Date _____

Doctor's Signature _____
(Required)

Date _____



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A. To be completed by parent or guardian:

I request that my child _____, grade _____, receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other assigned person will administer the medication.

Signature (parent or guardian) _____

Address: _____

Telephone: (Home) _____ (Work) _____ Date: _____

B. To be completed by the licensed health care provider:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

Time to be Taken During School Hours: _____ Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber & Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

Karen Jacobsen, RN
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