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
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:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

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

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_____ Date_____
(Required)

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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: _____

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