Please return to school nurse
School: Coleytown Middle

WESTPORT PUBLIC SCHOOLS
STUDENT MEDICAL EMERGENCY FORM 6th – 12th

2016-17

CHECK HERE ☐ IF INFORMATION BELOW IS NEW THIS SCHOOL YEAR

The medical emergency form must be completed for every student **each school year**. Please fill out and return the form *prior to the start of school* so we can reach you or an alternate at any time. Before listing an emergency contact - THINK CAREFULLY!! An emergency contact must be available to pick up a sick child. DO NOT list contacts without their consent.

STUDENT _____ DOB _____ GRADE _____

ADDRESS _____ PHONE _____

MOTHER _____ WORK # _____ CELL # _____

FATHER _____ WORK # _____ CELL # _____

(For business number, please list a direct line as well as main number where secretary/receptionist may be reached)

CUSTODY ARRANGEMENTS (if any) _____

DOCTOR _____ PHONE _____

DENTIST _____ PHONE _____

EMERGENCY CONTACT Name:_____ Relation:_____ PHONE _____
(Not yourself or a spouse)

EMERGENCY CONTACT Name:_____ Relation:_____ PHONE _____
(Not yourself or a spouse)

MEDICAL INFORMATION: Please provide current health and medication information necessary for staff to know in the event of an emergency. This information may be shared with Emergency Medical Services (EMS) personnel if 9-1-1 is called. Such information includes significant allergies (e.g., to nuts or medication), injuries, medical conditions or daily medication that may cause or impact an emergency. ***Please call the school nurse if you think your child may require an individualized emergency care plan (IECP) or individualized healthcare plan (IHCP) or to discuss confidential health information.***

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Please notify the school nurse immediately regarding any change in the above information.

Please indicate below if you give the school nurse permission to administer acetaminophen (generic Tylenol) to your child for headache, dysmenorrhea (menstrual cramps), orthodontic pain, or other pain according to the Standing Orders of the school medical advisor and professional judgment of the school nurse. The Standing Orders allow up to four (4) doses per month for students in high school and two (2) for students in middle school. However, **for more than four doses per month in high school, two in middle school** and for **all field trips**, administration of acetaminophen will require the written order of an authorized prescriber (e.g., your child's pediatrician) and a parent/guardian's permission documented on the district's standard medication authorization form.

YES ☐ NO ☐ PARENT/GUARDIAN SIGNATURE_____ DATE_____

For FEMALE *middle and high school students only*: If your student is female, please indicate below if you give the school nurse permission to administer ibuprofen (generic Advil) to your child for dysmenorrhea (menstrual cramps) according to the Standing Orders of the school medical advisor and professional judgment of the school nurse. The Standing Orders allow the administration of up to four (4) doses per month. However, for more than four doses per month and for **all field trips**, administration of ibuprofen will require the written order of an authorized prescriber (e.g., your child's pediatrician) and a parent/guardian's permission documented on the district's standard medication authorization form.

YES ☐ NO ☐ PARENT/GUARDIAN SIGNATURE_____ DATE_____

In the event of a medical emergency, as determined by the school nurse or other responsible staff member, it is the policy of the Westport Board of Education to call 9-1-1 immediately for EMS assistance and transport to the nearest approved medical facility. Other emergency interventions, as ordered by the school medical advisor (e.g., administration of EpiPen for an anaphylactic reaction) or as specified in a student's IECP/IHCP, will be implemented in the interim, as appropriate. School personnel will attempt to reach you and/or your child's doctor at the number(s) provided by you. Your child will receive medical treatment necessary to sustain life and stabilize his/her condition, as determined by the medical facility. Any further treatment must be authorized specifically by you or the person(s) designated by you.

PARENT/GUARDIAN SIGNATURE_____ DATE_____