



Little Chute Area School District

Health Services

Kara Kramer, RN, BSN, School Nurse 788-7600 x3302

Student's
Picture

325 Meulemans St Suite A, Little Chute, WI 54140

Fax (920) 788- 7603

Student's Name:	DOB:	Date:
School Attending:	Grade:	Bus Student: Yes No
Health Condition: Bee Sting Allergy (Known) – Emergency Care		
EMERGENCY PROCEDURE: 1. Give appropriate medication as listed below. 2. If EpiPen given, call 911: State that an allergic reaction has been treated. 3. Additional epinephrine may be needed. If symptoms continue, repeat epi-injector after 5-10 minutes. 4. Stay with student and monitor. 5. If self-administered, student must notify school personnel.		
EMERGENCY CONTACT: Name:	Phone:	Relationship to student:
FOR COMPLETION BY PHYSICIAN: Physician's Name: Phone:		
Epinephrine:	Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Auvi-Q™ 0.3 mg Auvi-Q™ 0.15 mg	
Antihistamine:	give: medication/dose/route _____	
Other:	give: medication/dose/route _____	
IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.		
Is the child knowledgeable about his or her medication & need to notify school personnel if epinephrine is administered: Yes ____ No ____		
Has the child demonstrated the proper technique in administering medication: Yes ____ No ____		
Side effects:		
() I have instructed _____ in the proper way to use his/her injected medications. It is my professional opinion that he/she should be allowed to carry and use this injected medication by him/herself.		
() It is my professional opinion that _____ should not carry and use his/her injected medication by him/herself.		
Physician's Signature:		Date:
FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer Epinephrine: Yes ____ No ____		
Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Little Chute School District, and the LCSD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary. If self-medication is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.		
I have reviewed the health plan for my child: _____ The plan is correct as written _____ The plan is correct with the changes noted above		
Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff.		
Parent Signature:		Date:
Rev. 05/2014		

Principal's Initials _____