Student's Name: _____ Grade: _____

**2025-2026**
**Standing Orders**

**A complete copy of Standing Orders/Administration Protocols and Fluoride Rinse is available at the Health Office**

I hereby authorize the Petersham Center School nurse to:

[ ] 1. Administer acetaminophen (i.e. Tylenol) according to recommended dosage by age/weight.

[ ] 2. Topical agents:
- Bacitracin Ointment for superficial wound care
- Calamine Lotion for contact dermatitis, insect bites, or generalized skin irritations
- Petroleum Jelly (i.e. Vaseline, Aquaphor) for chapped or dry skin
- Hand Sanitizer Foam/Gel (70% alcohol)
- Administer antacids in the form of tablets (like Tums), 1-2 tablets every four hours as needed to students complaining of heartburn or stomach upset.

***In the event a life threatening allergic reaction (anaphylaxis) should occur to students that have not been previously diagnosed with an allergy (i.e. food or insect bites), epinephrine will be given by auto-injector (EpiPen).***

All students must have this written authorization from their parent/guardian to receive these medications. Any other medications other than those listed above (prescription or **over-the-counter, including cold medicine, anti-histamines, cough drops, creams/ointments, etc)** ***WILL NOT*** be available or administered unless prescribed by a physician and will need to be provided by the parent. Medication will be administered according to the established protocols for administration stated above and state and local policies and procedures. (DPH regulations105 CMR 210.000)

***Please complete all information [check off the appropriate boxes above] and sign below.***

**PARENTS ARE REMINDED THAT CHILDREN *MAY NOT CARRY* ANY MEDICATIONS - INCLUDING COUGH DROPS - IN SCHOOL AND SELF MEDICATE without the written approval of their physician, the school nurse and the parent.**

Parent/guardian signature _____ Date: _____

Please list any **allergies/medical conditions,** the student's reaction and required treatment:
(All treatments must be accompanied by a physician's order)

| Allergy/Condition | Reaction | Treatment |
|---|---|---|
| | | |

Please list any medical conditions, health concerns and comments not listed above:

_____

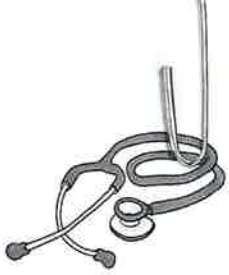
_____

_____

Any routine prescription medications being taken: _____

I give permission for the school nurse to share necessary medical information with the staff members responsible for my child at school. [ ] Yes. [ ] No

Parent/guardian signature _____ Date: _____



2025/2026
Petersham Center School

Student Health History form

Office of the School Nurse

31 Spring St., PO Box 128
Petersham, MA 01366
Phone 978-724-3363 Fax 978-724-6687

Christine Warburton, RN
School Nurse
christine.warburton@petershamcenterschool.org

Date: _____

**Student name:** _____ **Date of Birth:** _____ **Grade** ____

Dear parent/guardian,

**Welcome to Petersham Center School!** In order to provide proper care and comfort to your child please take a few moments to answer the following questions.

**Allergies**

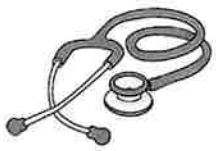
Does your child have any allergies? _____ No _____ Yes If **YES**, please answer the following questions:
My child is allergic to: (i.e., food, medicine, animal, environmental) Please list below.

| Allergy | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please check if your child has any of these conditions:**

- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD)
- ☐ Attention Deficit Hyperactive Disorder (ADHD)
- ☐ Diabetes
- ☐ Eating Disorder or Weight Concerns
- ☐ Epilepsy or Seizure Disorder
- ☐ Frequent nosebleeds
- ☐ Glasses/contacts ☐ Full Time ☐ Part Time
- ☐ Other health conditions _____
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hospitalizations _____
- ☐ Migraine Headaches
- ☐ Skin Problems
- ☐ Surgery _____

***PLEASE COMPLETE REVERSE SIDE***



2025/2026

Petersham Center School

## Office of the School Nurse

Does your child take any daily medications including over-the-counter medications? _____ No _____ Yes

If yes, please list:

| Medication | Dosage | Frequency | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Does medication need to be given at school?** ___ No ___Yes ***If yes, please contact the school nurse so that the appropriate forms can be completed.***

Any other information that you feel would be helpful for the school nurse to know? (i.e., pertinent family medical history, family changes, prenatal/birth history, other)

_____

_____

Does your child wear/require any hearing assist devices? _____Please explain _____

_____

Does your child require any other assistive devices? _____

Please explain _____

_____

**Child's Physician/Therapist:**

Name:_____Phone:_____

Name:_____Phone:_____

***Do we have permission to contact and/or share information with the above listed physician/therapist? Yes__ No__***

**Parent Contact Information:**

Mother/Guardian: _____ Home# _____

Cell #_____ Work#_____

Father/Guardian: _____ Home# _____

Cell #_____ Work#_____

Emergency Person: _____ Phone: _____

**New students must have a record on file of a physical exam done within the past year and proof of required immunizations. Please forward a copy or follow up with your primary care provider and forward the appropriate documentation**.

***I give the school nurse permission to speak with my child's physician regarding the care of my child*** □ **Yes** □ **No**

Parent/guardian signature _____ Date: _____

If you have any health concerns, please feel free to contact my office at any time. Thank you for providing this very important information.

Christine Warburton, BSN, RN

Student Health Information Updated (3/2025)

# FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

## SEVERE SYMPTOMS

**LUNG**
Shortness of breath, wheezing, repetitive cough

**HEART**
Pale or bluish skin, faintness, weak pulse, dizziness

**THROAT**
Tight or hoarse throat, trouble breathing or swallowing

**MOUTH**
Significant swelling of the tongue or lips

**SKIN**
Many hives over body, widespread redness

**GUT**
Repetitive vomiting, severe diarrhea

**OTHER**
Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

**NOSE**
Itchy or runny nose, sneezing

**MOUTH**
Itchy mouth

**SKIN**
A few hives, mild itch

**GUT**
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

# Massachusetts Asthma Action Plan

| Name: | | Date: |
|---|---|---|
| Birth Date: | Doctor/Nurse Name: | Doctor/Nurse Phone #: |
| Patient Goal: | | Parent/Guardian Name & Phone #: |
| Important! Avoid things that make your asthma worse: | | |

Personal Best Peak Flow: _____

**The colors of a traffic light will help you use your asthma medicine.**

**GREEN means Go Zone!**
Use controller medicine.

**YELLOW means Caution Zone!**
Add quick-relief medicine.

**RED means Danger Zone!**
Get help from a doctor.

## GO — You're doing well!

**You have *all* of these:**

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

**Use these daily controller medicines**

| Peak flow from ___ to ___ | MEDICINE/ROUTE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CAUTION — Slow Down!

**You have *any* of these:**

- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Coughing, wheezing or trouble breathing at night

**Continue with green zone medicine and add:**

| Peak flow from ___ to ___ | MEDICINE/ROUTE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

CALL YOUR DOCTOR/NURSE: _____

## DANGER — Get Help!

**Your asthma is getting worse fast:**

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

**Take these medicines and call your doctor now.**

| Peak flow from ___ to ___ | MEDICINE/ROUTE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. DO NOT WAIT.**

Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature _____ **DATE** _____

I give permission to the school nurse, my child's doctor/NP/PA or _____ to share information about my child's asthma.

Parent/Guardian Signature _____ **DATE** _____

**— SEE BACK OF SCHOOL COPY FOR STUDENT MEDICATION ADMINISTRATION AUTHORIZATION —**

ADAPTED FROM NIH PUBLICATION (7/20/01)

*Make copies of this plan for: patient/parent, provider, and school.*