INDIVIDUAL HEALTH PLAN / EMERGENCY CARE PLAN FOR STUDENT WITH SEVERE ALLERGY

TO BE RENEWED EACH SCHOOL YEAR
(If you need assistance completing this form, contact the Licensed School Nurse.)

Student Name_____ Birth Date: _____
School_____ Grade_____ Teacher_____ School Year_____

According to our records, your child has a severe allergy which requires emergency medication and/or cares. Completion of this form will keep your child's health record current.

1. **My child still has this allergy:**

YES Complete form, sign & date back, and return to your child's school.

NO Parent/Guardian signature: _____ Date:_____
(If "No" is checked, do not fill out the remainder of the form, but sign and return to your child's school.)

2. My child is allergic to:_____
3. Reaction occurs from: ◯ ingestion ◯ contact ◯ inhalation ◯ insect sting
4. My child has had a life threatening, anaphylactic reaction to this allergen: YES ◯ NO ◯
5. Does your child also have asthma? YES (*Higher risk for severe allergic reaction*) ◯ NO ◯

SIGNS OF AN ALLERGIC REACTION INCLUDE:

(Please check symptoms most common to your child.)

MOUTH	SKIN	GUT	THROAT	LUNGS	HEART	OTHER
☐	☐	☐	☐	☐	☐	☐
						
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	feeling something bad is about to happen, anxiety, confusion

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

6. History of reaction (date of last reaction / signs & symptoms of reaction):

_____

7. Does your child recognize these signs and symptoms? YES ◯ NO ◯
8. Will your child require a rescue medication to be given at school? YES ◯ NO ◯
   If yes, epinephrine auto-injector will be kept: In health office With student (secondary only)
   epinephrine expiration date: _____
9. Health Care Provider Name:_____ Phone # _____
10. Emergency Contacts (*list in order of who to call first*)

Name:_____ Relationship:_____ Phone:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____ Phone:_____

FOOD ALLERGIES

My child can identify all foods that should be avoided and can self-manage their food intake at school:

YES ◯ NO (explain): _____

It is the responsibility of the parent/guardian to review lunch menus and coordinate with the health office, dietary, and classroom teacher on how to manage mealtime, classroom snacks, and art projects. ***The school cannot guarantee that the facility or dining area will be allergen free.*

OVER

Student Name:_____

SCHOOL ACTION/EMERGENCY PLAN (if exposure to allergen occurs):

If student has an epinephrine auto-injector for a bee sting allergy, it will be immediately given if stung*

1. Give prescribed medications if available. If symptoms do not improve, or symptoms return, additional dose of epinephrine can be given (if ordered by a licensed prescriber and authorized by parent/guardian).
2. Call 911. Tell emergency dispatcher the person may be having anaphylaxis.
3. 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. Calm and reassure student.
4. Contact parents/guardian.
5. Emergency transportation to hospital is recommended for further monitoring.

(The Consent Form for Administration of Emergency Allergy Medication During the School Day for an epinephrine auto-injector must be completed and signed by the health care provider and parent.)

SCHOOL MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

No epinephrine auto-injector at school. Follow School Emergency Action Plan.

Student needs help with allergy signs and symptoms; epinephrine auto-injector will be administered as ordered. The epinephrine auto-injector must be properly labeled for the student.

1. I understand that this information may be shared with all school staff who work directly with my child.
2. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her allergy plan.
3. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
4. Field trips - I give permission for a trained teacher/school personnel to administer the medication on a field trip.
5. I will provide this medication in the original, properly labeled pharmacy container and *understand the school does not have stock epinephrine auto-injectors.*
6. I release school personnel from any liability in relation to the administration of this medication at school. (Administration of this medication will not necessarily be done by the Licensed School Nurse.)
7. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's health plan.**
8. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

Parent/Guardian Signature _____ **Date** _____

OR

STUDENT SELF-MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION (for secondary students only)

Student can self-manage allergy signs and symptoms, **no epinephrine auto-injector at school.**

- Student will go to the health office if allergic reaction occurs, and 911 and parent will be called.

Student can self-manage allergy signs and symptoms and **may independently carry/use epinephrine auto-injector at school**.

- The health office staff will assess the student's knowledge and skills to safely possess and use his/her epinephrine auto-injector in a school setting. If non-compliance or a change in status occurs, the Licensed School Nurse will contact parent/guardian to discuss a new Agreement.
- *Students who self-manage their allergy will NOT be monitored by school personnel on a daily basis*

1. If epinephrine auto-injector is needed at school, I request my child self-manage his/her allergy and be responsible for carrying the epinephrine auto-injector and administering as prescribed.
2. My child will notify a school staff member if he or she administers epinephrine so 911 can be called.
3. I understand that this information may be shared with all school staff who work directly with my child.
4. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her allergy plan.
5. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
6. I understand the school does NOT have stock epinephrine auto-injectors, and emergency rescue medication is not available if the student fails to bring his/her epinephrine auto-injector or keep it at school or in his/her bag.
7. **I understand that my child will inform all staff, including teachers, coaches, and bus drivers, of his/her allergy, health plan, and will be responsible to carry the epinephrine auto-injector on field trips**.
8. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

Parent/Guardian Signature _____ **Date** _____

LICENSED SCHOOL NURSE SIGNATURE:_____ Date:_____

CONSENT FORM FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION DURING SCHOOL DAY

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the LIcensed School Nurse)

****Before medication can be administered by school personnel this form must be completed and on file with the school health office****

Student Name____Birth Date ___________________

School _____________________ Grade _______ Teacher ________________ School Year __________

* *

PHYSICIAN / LICENSED PRESCRIBER ORDER

Medication: Epinephrine auto-injector type:__________________________Dose: 0.15 mg IM 0.3 mg IM

Instructions for giving medication:____

Criteria for repeat dosing:_______

Possible side effects: ___________

Other/Additional Directions: ____

Emergency Allergy Medication should be administered for the following type(s) of symptoms:

MOUTH	SKIN	GUT	THROAT	LUNGS	HEART	OTHER
☐	☐	☐	☐	☐	☐	☐
						
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	feeling something bad is about to happen, anxiety, confusion

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

This student has received instruction and permission to self carry and independently manage: YES ◯ NO ◯

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE:_______________________________DATE:__________

PRINT NAME:________________________Clinic______________Phone #:_________Fax #__________

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PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during regular school hours as ordered by the physician/licensed prescriber.
2. I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. I will provide this medication in the original, properly labeled pharmacy container.
4. I authorize the Licensed School Nurse/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
5. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my child.
6. I release school personnel from any liability in relation to the administration of this medication at school.
7. I have read and understand the Medication Guidelines included with this form.
8. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

Parent/Guardian Signature:___________________________________Date:_______________

LICENSED SCHOOL NURSE SIGNATURE:__________________________Date:_______________

GUIDELINES FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION IN SCHOOL

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Allergy Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian and Licensed School Nurse. Non-prescription medication may be administered to students with written authorization of parent/guardian and Licensed School Nurse according to label directions.
    a. Mixed dosages in a single container will not be accepted for administration at school.
    b. If a half tablet is required for a correct dosage, it is the parent/guardian's responsibility to provide pre-cut tablets for administration at school.
    c. Altered forms of medication will not be accepted or administered at school.
    d. Narcotics/medical cannabis will not be administered at school.
    e. Aspirin-containing products will not be administered at school.
    f. Only FDA approved treatments will be provided at school.

2. The medication must be brought to school by a parent/guardian in its original container. The following information must be on the medication container:
    a. Student's full name
    b. Name and dosage of medication
    c. Directions for administration must match the authorization form
    d. Physician/Licensed Prescriber name
    e. Date (must be current)

3. New consent forms with appropriate signatures must be received each school year.

4. A new medication consent form is required when the medication dosage or instructions for administering the medication are changed.

5. If the medication is discontinued, a physician/licensed prescriber is requested.

6. Medication will be kept in a locked cabinet in the health office unless authorized by the Licensed School Nurse, and must not be carried by student.

7. Students (grades 6-12) with severe allergies who need their epinephrine auto-injector during the school day will be allowed to self-manage, carry, and be responsible for the administration of their epinephrine auto-injector with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the Licensed School Nurse.

8. Secondary students may carry and use **non-prescription** medication with written consent of their parent/guardian, signature of student agreement, and with consent of the Licensed School Nurse. This medication cannot contain ephedrine/pseudoephedrine or aspirin as its sole active ingredient or as one of its active ingredients.