KENNEWICK SCHOOL DISTRICT

Individual Health Plan
Severe Allergic Reaction

Completed by Health Care Provider

Student Photo

Name: Birth Date:

Specify Allergen ***(Indicate if contact allergy and/or ingestion only allergy)*:**

☐ Insect stings, Specify: _____

☐ Nuts, Specify: _____ Contact allergy__ Ingestion only allergy___

☐ Other, Specify: _____ Contact allergy__ Ingestion only allergy___

Confirmed by testing? Yes ☐ No☐, If yes, Type of testing: _____Date of testing: _____

Other method of diagnosis:_____

Brief description of previous reactions:_____

THIS STUDENT'S ALLERGY IS LIFE THREATENING

☐ ***YES (EpiPen/Emergency Tx Required)*** ***OR*** ☐ ***NO***

Symptoms: *Can change quickly and rapidly progress to a life-threatening situation!*

- **Mental:** Feels "scared"; something bad is going to happen
- **Respiratory:** Itching or swelling of lips, tongue, mouth, throat, hoarseness, coughing, difficulty breathing
- **Skin:** Hives, itching, swelling, red/blotchy skin
- **Gut:** Nausea, vomiting, cramps, diarrhea
- **Heart:** Irregular pulse, rapid pulse, fainting
- **Other:**_____

Action Plan for Severe Allergic Reaction

*__*Never send alone if having a possible reaction; call office for help or notify coming with escort*__

Do: If having symptoms of allergic reaction or known exposure	**Then do:**
• **Give Epi-Pen, note time given** • **Call 911**	• Stay with student • Begin CPR if the need arises • Have another school employee contact parents and school nurse if not in building

Further recommendations from HCP: ***(classroom, school bus, field trips, disaster etc.)***

Name of Medication(s) needed at school	Dose	Time of day to be given
Side effects of drug (if any) to be expected:		
Length of time this authorization is valid (no longer than current school year):		

I request and authorize this student to carry their medication/self-administer. They have demonstrated proper use in my office. **Yes No** **School Nurse approval**_____

Health Care Provider Signature:	Date:
Health Care Provider name (print or type)	
Phone:	Fax:
School Nurse Signature:	Date:

Parent Permission (*to be completed by parent or guardian*)

- By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the administration of medication by the KSD staff or as self-administered by the student.
- Parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication.

Signature of parent or guardian: _____ Date: _____

MEDICATION AT SCHOOL RULES

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed **oral, nasal spray, topical, eye drop or ear drop** medication and over-the-counter **oral, nasal spray, topical, eye drop or ear drop** medication should be dispensed before and/or after school hours under supervision of the parent / guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed heath care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

Authorization for Mutual Exchange of Confidential Information

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: _____ Date: _____ DOB: _____

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:** ***KSD Nurse***	
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:** ***Kennewick, WA,***	
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe records to be disclosed: ***Diagnoses, medication, medical recommendations applicable for student at school.***

The reason for disclosing the record(s) is: ***To provide safe care of the student in the educational setting***

This authorization is valid from: _____/_____/_____ to: _____/_____/_____.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/student signature:	Date: