Boone County Schools
School Health Services Department

Allergy Health Care Plan

Plan Date: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Allergic to the following: _____

Student has Asthma: ☐ **NO** ☐ **YES** (If yes, **higher** chance of reaction)

History of Anaphylaxis: ☐ **NO** ☐ **YES**

Has emergency medical treatment been needed in the last year for allergic reaction? ☐ **NO** ☐ **YES**

Please mark the signs that are usually present during an allergic reaction

_____ rash	_____ lips and/or tongue swelling	_____ difficulty breathing
_____ hives	_____ facial swelling	_____ nausea/ vomiting
_____ flushed or pale skin	_____ difficulty swallowing	_____ loss of consciousness

Other: _____

For Mild Allergic Reaction

What to look for:

If child has had any mild symptoms, monitor child.
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child

What to do:

Stay with child and:

- Watch child closely.
- **Give antihistamine (if available).**
- Call parents and child's doctor.
- If after 10 minutes or if symptoms of severe allergy/anaphylaxis develop, use epinephrine

For Severe Allergy and Anaphylaxis

What to look for:

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin: pale or has a bluish color, many hives
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of "doom," confusion, altered consciousness, or agitation.

☐ **Special Situation**: If this box is checked, child has an extremely severe allergy. **Even if child has mild symptoms, give epinephrine.**

Give epinephrine!

What to do:

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give second dose of epinephrine, if ordered by physician
   - Keep child lying on back.
   - If child vomits/ or has trouble breathing, keep child lying on his/ her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

For School Nurse Use Only	
_____ Stable history	_____ No ongoing nursing management at school needed
_____ Potential complications, Hypoxemia	_____ Standard procedures for reactive airway disease
_____ High risk factors for ineffective breathing pattern	_____ Standard school medication procedure
_____ Other	_____ Individual HCP
_____ Delegated or assigned caregiver name and date trained _____	
Reviewed Date: _____ Nurse Signature: _____	

Revised: Nov. 2018 SLW

Boone County Schools
School Health Services Department

Medication Administration Consent Form

In-school/ After-school hours/ Field trip (including self-administration)

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week's supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

Allergies: _____

****Please advise the school nurse immediately of any changes in medication or dosing.****

Medication 1: _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

**** In the case of emergency medication (inhaler, epinephrine, glucagon, or FDA approved seizure medication) this student has received training, and is capable of the following:**

Physician's initial in appropriate box(s)	_____ may **CARRY** medication	_____ may **SELF-ADMINISTER** medication

Medication 2: _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

**** In the case of emergency medication (inhaler, epinephrine, glucagon, or FDA approved seizure medication) this student has received training, and is capable of the following:**

Physician's initial in appropriate box(s)	_____ may **CARRY** medication	_____ may **SELF-ADMINISTER** medication

Specific to field trips: In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on an in-state or out-of-state field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

Trained Unlicensed School Personnel: The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administrating the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student's physician in the case of a life threatening emergency wherein immediate intervention is required.

Parent/ Guardian signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

Physician name: _____ **Phone number:** _____

Staff administering medication are trained annually by a registered nurse.

Boone County Schools
School Health Services Department
Food Allergy Cafeteria Information

Student Name: _____ Date of Birth: _____

Teacher Name: _____ Grade: _____

Food Allergies:

Food	Allergy	Intolerance	Reaction
(example) Peanut	X		hives, trouble breathing

Does this student need to sit at an allergy table at lunch? ☐ **YES** ☐ **NO**

Can the student be around the allergen (air born reaction- this is used for classroom parties)? ☐ **YES** ☐ **NO**

Parent Signature: _____ **Date:** _____

*****In response to the COVID-19 pandemic; under the guidance of CDC, Kentucky Department of Education and local health department, small modification will be made during the school day to accommodate the needs and safety of the student. It is Boone County's policy to keep the privacy and integrate of the student's health while providing a safe environment; all proper health checks and laws still apply during the modification.*****

Eating and Feeding Evaluation: Children with Special Needs

Part A			
Student's Name:		Age:	
Name of School:	Grade:	Class:	
Does the child have a disability? If yes, describe the major life activities affected by the disability		**Yes**	**No**
Does the child have special nutritional or feeding needs? If yes, complete **Part B** of this form and have it signed by a licensed physician.		**Yes**	**No**
If the child is not disabled, does the child have special nutritional or feeding needs? If yes, complete Part B of this form and have it signed by a recognized medical authority.		**Yes**	**No**
If the child does not require special meals, the parent can sign at the bottom and return the form to school food services			
Part B			
List any dietary restrictions:			
List any allergies or food intolerances to avoid:			
List foods to be substituted:			
List foods that need the following change in texture. If all foods need to be prepared in the manner, indicate "ALL". Cut up or chopped into bite sized pieces: Finely ground: Pureed:			
List any special equipment or utensils that are needed:			
Indicate any other comments about the child's eating or feeding patterns:			
Parent's Signature:	Date:		
Physician's or Medical Authority's Signature:	Date:		

Student's Emergency Medication Location	
☐ First Aid Room	☐ Self-carries; Location: _____

Boone County Schools
Student Services Division
School Health Services Department
Transportation/Student Health Concerns

Photo

School Year: _____

Student Name: _____

Address: _____

Bus Number: _____ **School:** _____

Date of Birth: _____ **Age:** _____ **Grade:** _____

Health concern of student: _____

Medication/supplies which will be with student during bus transportation: _____

_____

Is student responsible for medication administration? Yes ☐ No ☐

Emergency care to be given to student by bus driver: _____

_____

Comments: _____

Parent /Guardian signature: _____

Daytime phone number: _____ Date: _____

This completed form must be returned to your child's school office in order for transportation to be notified.

School nurse is to scan completed form to Transportation: cynthia.buttery@boone.kyschools.us