CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Diana Taylor RN BSN
Campbell County Health Services Coordinator
Phone: (859)635-2173, ext: 1008

Dear Parent/Guardian

In preparation for the upcoming school year, it is important that we have accurate information/authorization to the special health-care needs of your child in the school setting.

Please have your child's physician complete the information on the appropriate forms prior to the beginning of the new school year. This information will be used to develop an Individualized Health Care Plan for your child in the school setting. Medications/procedures will not be administered until all forms are properly completed/signed by the parent and physician, and the parent/guardian provides medications and all supplies required.

All packets and medication forms are available on the Campbell County web page on the Health Services tab under "Departments". If your child has diabetes, Children's Hospital provides a school packet containing all information required for school attendance for those students managed through their clinic. Please contact them now and request that the packet be completed.

After July 25, please contact the nurse of the school your child will attend to set a time to meet with appropriate staff. If you have further questions, please contact me at: 859-635-2173, ext: 1008.

Thank you in advance for your cooperation. With your assistance we can insure a smooth transition for your child into the new school year.

Sincerely,

Diana Taylor RN

CAMPBELL COUNTY HEALTH SERVICES
ALLERGY INDIVIDUAL HEALTH CARE PLAN (IHP)

NAME: _____ DATE OF BIRTH: _____ SCHOOL YEAR: _____ GRADE: _____
SCHOOL: _____ TEACHER: _____ EXT: _____
BUS #: _____ CAR RIDER _____

ALLERGIC TO: _____ DATE OF LAST REACTION: _____

SIGNS/SYMPTOMS WITH EXPOSURE:

ASTHMA: (High risk for severe reaction)
_____ yes _____ no

Location of rescue meds:
_____ Office _____ Backpack _____ Self-Carry _____ Classroom _____ Coach _____ Other

ALLERGY SYMPTOMS: IF SEVERE REACTION IS SUSPECTED GIVE RESCUE MED IMMEDIATELY & CALL 911

MOUTH:	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN:	Hives, itchy rash, and/or swelling about the face or extremities
THROAT:	Sense of tightness in the throat, hoarseness, and hacking cough
GUT:	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG:	Shortness of breath, repetitive coughing, and/or wheezing
HEART:	"Thready" pulse, "passing out", fainting, blueness, pale
GENERAL:	Panic, sudden fatigue, chills, fear of impending doom
OTHER:	Some students may experience symptoms other than those listed above

RESCUE MEDICATIONS TO BE ADMINISTERED IN EVENT OF EXPOSURE

MILD REACTION:
SYMPTOM(S): _____ MEDICATION (ANTIHISTAMINE):_____ DOSAGE: _____

SEVERE REACTION: AIRWAY DISTRESS or PRESENCE OF 2 OR MORE ALLERGY SIGNS/SYMPTOMS:

MEDICATION: _____ DOSAGE: _____ ROUTE OF ADMINISTRATION: _____
2ND DOSE AVAILABLE: YES NO

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES**
  ***TIME ANTIHISTAMINE GIVEN _____AM/PM *TIME RESCUE MED ADMINISTERED _____AM/PM**
- **Call 911 immediately. 911 must be called WHENEVER a rescue medication is administered.**
- **DO NOT HESITATE to administer the rescue medication and to call 911 even if the parents can't be reached**
- Advise 911 student is having a severe allergic reaction & their rescue medication is being administered
- An adult trained in CPR is to stay with the student to monitor & begin CPR if necessary
- Call the School Nurse at _____ or the Main Office at _____
- Student should remain with staff member trained in CPR at the location where symptoms began until EMS arrives
- Notify the administrator and parent/guardian
- Dispose of used rescue medication containers in "sharps" or give to EMS if student being transported

CAMPBELL COUNTY HEALTH SERVICES
ALLERGY CARE PLAN (CONT.)

INDIVIDUAL CONSIDERATIONS

Bus – Transportation should be alerted to student's allergy

- This student carries their allergy rescue med on the bus: _____ YES _____ NO
- Rescue med can be found in: _____ Backpack _____ On person _____ Other: _____
- Student will sit at the front of the bus: _____ YES _____ NO
- Other considerations: _____

FIELD TRIP PROCEDURES

Rescue med should accompany student during any off- campus activities

- Student should remain with the teacher/guardian during entire field trip: _____ YES _____ NO
- Staff members on trip must be trained regarding administration of rescue med and must have copy of student's Health Care Plan.
- Other: _____

CLASSROOM (Food allergy)

Student must avoid these foods: _____

- All snacks/treats must be in manufacturer's packaging with ingredients listed
- If unsure about a packaged snack, contact parent prior to giving to student
- Middle/High School student will be making their own decisions: ____ YES ____ NO
- Alternative snacks will be provided by parents for parties/rewards: ____ YES _____ NO
- Parent/Guardian should be advised of all parties/rewards as early as possible.
- Classroom projects involving food items should be reviewed by teaching staff/nurse to avoid allergen
- Other: _____

CAFETERIA

CAFETERIA STAFF SHOULD BE NOTIFIED OF ALL FOOD ALLERGIES

- No restrictions: _____ YES _____ NO
- Student will sit at a specified allergy table during lunch: _____ YES _____ NO
- Cafeteria staff will ensure student table sanitized before student eats
- Other: _____

Physician Signature: _____ Physician Printed Name: _____
Physician Phone Number: _____

Parent/Guardian Signature: _____ Phone Number: _____

Emergency Contact #1 Name: _____ Phone Number: _____
Emergency Contact #2 Name: _____ Phone Number: _____

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Consent for Administration of Medication at School

Student Name: _____ Grade: ____ Teacher: _____

School: _____

Name of Medication: _____

Dosage: _____ Time(s) of administration: _____ _____ _____

As Needed (PRN): Indicators for use: _____

Route of Administration: _____

Diagnosis or Reason for Medication to be Administered: _____

Possible Side-Effects: _____

Student Allergies: _____

Physician Authorization

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Guardian Authorization

I authorize an employee of the school to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage/times of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order.
I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and expiration date of medication.
I waiver any liability on behalf of the school as a result of administration of the above medication.

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian Phone: _____

Contact #2 Name: _____ Phone: _____

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Consent for Administration of Medication at School

Student Name: _____ Grade: ____ Teacher: _____

School: _____

Name of Medication: _____

Dosage: _____ Time(s) of administration: _____ _____ _____

As Needed (PRN): Indicators for use: _____

Route of Administration: _____

Diagnosis or Reason for Medication to be Administered: _____

Possible Side-Effects: _____

Student Allergies: _____

Physician Authorization

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Guardian Authorization

I authorize an employee of the school to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage/times of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order.
I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and expiration date of medication.
I waiver any liability on behalf of the school as a result of administration of the above medication.

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian Phone: _____

Contact #2 Name: _____ Phone: _____

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Authorization to Carry/Self-Administer Medication

Pursuant to the laws of the Commonwealth of Kentucky and Campbell County Schools Board Policy, students may be Granted permission to carry and self-administer medication for use as needed during school hours and during school sponsored activities. This is limited to medication for treatment of asthma, severe allergic reaction, or diabetes. The student must have training in the proper use and administration of the medication named and be responsible for safe use.

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Condition for which Medication is Prescribed: _____

Medication Name: _____ Dosage: _____ Route of Administration: _____

Time/Frequency of Administration: _____ If PRN (as needed) frequency: _____

If PRN (as needed), for what observable signs/symptoms: _____

Possible/Relevant Side Effects: _____

Additional Instructions/Follow Up: _____

****This student has been instructed on self-administration & shows capability to carry and self-administer this medication. He is authorized to do so in school****

Physician Signature: _____ Printed Name: _____
Phone Number: _____ Date: _____

Parent/Guardian Authorization

I request that my child be permitted to carry and self-administer the medication ordered above. I understand the medication must be in its original prescription container. I accept responsibility for this permission and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school and its employees/agents, harmless against any claims relating to the self-administration of such medication.

Parent Signature: _____ Date: _____

AGREEMENT FOR THE ADMINISTRATION OF EMERGENCY CARE

The undersigned parent/guardian of _____
a pupil in the Campbell County Public Schools, has advised the Board of Education of Campbell County that his/her child named above suffers from a medical condition which may be life threatening unless immediate emergency care is provided in a crisis which may arise from the child's health problem.

Accordingly, the Board of Education of Campbell County has adopted a procedure wherein a member of the staff of the school the child is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the child's physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.

The undersigned parent/guardian does hereby consent to the intervention of the volunteer staff member in accordance with the instructions contained in the attached letter from the child's physician. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

Dated at Alexandria, Kentucky, this the _____ day of _____. _____
(Day) (Month) (Year)

X _____
(Parent/Guardian Signature)