OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM

ALLEGY CARE PLAN/PRESCRIBED EPINEPHRINE 9009.04F

Student Name: ____ DOB: _______________ Grade: _______

School: ____ School Year: __________ Teacher: ______________

ACTION PLAN TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER

ALLERGIC TO: ____

Asthma: Yes (Higher risk for severe reaction) No

Date of last reaction:___________________ Symptoms: ____

History of anaphylaxis? *Yes No *If yes, give date ________________________________

STUDENT TO SIT AT NUT FREE TABLE: Yes No

SEVERE SYMPTOMS

FOR ANY OF THE FOLLOWING SEVERE SYMPTONS:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, bluish skin, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing or swallowing
MOUTH: Significant swelling of the tongue or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea

WHAT TO DO:

1. **Call 911 and parent**
   INJECT EPINEPHRINE IMMEDIATELY
2. **Give additional medications, if prescribed**
3. **Monitor student until EMS arrives**
4. **If symptoms do not improve or return, a second dose can be given 5 minutes or more after last dose**
5. **It is highly recommended to transport to ER, even if symptoms resolve. If parent refuses transport, student will be sent home for the day**

MILD SYMPTOMS

NOSE: Itchy or runny nose, sneezing
MOUTH: Itchy mouth
SKIN: A few hives, mild itch
GUT: Mild nausea or discomfort

WHAT TO DO:

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** BODY SYSTEM AREA-**GIVE EPINEPHRINE IMMEDIATELY**

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

1. *Give antihistamine, if prescribed
2. Notify parent, stay with student
3. Watch for changes.
4. If symptoms worsen, **GIVE EPINEPHRINE IMMEDIATELY**

*If antihistamine given, student will be sent home for observation

MEDICATIONS

Epinephrine (list type): ____ Expires: ______________

Dose 0.15 0.30

Antihistamine (type and dose): ____ Expires: ______________

Other: ____ Expires: ______________

Location of Medication:

- ☐ School Office/Health Room
- ☐ *Carried by Student *Physician has instructed student in proper care, storage and use of this medication (KRS 158.834)

_____________________________________ _____________________ ______________
Physician Name and Signature (required) *Date* *Phone*

I have read and agree with above physician orders for my child:

____ _____________________
Parent Signature *Date*

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EMERGENCY CONTACT INFORMATION:
It is the responsibility of the parent/guardian to provide current contact information that includes working phone numbers for parents, guardians and emergency contact persons.

Parent/Guardian: ____ Phone: ____________________

Parent/Guardian: ____ Phone: ____________________

Emergency Contact: ____ Phone: ____________________

*If medication is to be kept on student's person, the guardian agrees that the medication will be carried in a secure, protective container and that the medication will be labeled with student's name. Guardian also agrees that the replacement of expired medication is the responsibility of the guardian. When a student is authorized by their physician and parent/guardian to possess a prescribed life-sustaining medication, it is recommended that an additional dose of medication is kept in the school office. In the event the prescribed medication is discontinued by the physician, the parent/guardian will notify their student's school office by providing a written statement from the prescribing physician. **The parent/guardian understands that it is the student's responsibility to be in possession of prescribed medication during the school day, while attending field trips and while participating in extracurricular activities. See: Medication Policy 9020.01 – AR. School staff do not verify possession of medication when students are authorized to carry on their person.**

In the event of a crisis requiring immediate intervention, a trained school employee will administer an injection or other prescribed drug. The undersigned understands that the employee administering the prescribed medication is not a licensed healthcare professional. The employee will make his or her best effort to comply with the recommended procedure developed by the child's physician, and in accordance with the training conducted by a registered nurse. The undersigned hereby consents to the intervention of the employee under these circumstances.

Additionally, the undersigned agrees to hold the Oldham County Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the employee's negligence. The parent/guardian further agrees to indemnify and hold harmless any employee and the Oldham County Board of Education and its members from any claim resulting from the student's self-administration of medication per state law. The permission for self-administration of medication shall be in effect for the school year in which it is granted and shall be renewed each following school year. (KRS-158.834)

Parent/Guardian hereby gives consent for the child's medical records and reports to be shared with the Oldham County Board of Education and its employees, and for my child's physicians to discuss his/her medical condition referenced above with school or District personnel to assist them in planning for my child's care while at school or school events.

____ ____________________
Parent/Guardian Signature (mandatory) *Date*

Office Use Only

Care Plan rec'd by: ______________________________ Date: ____________________

Medication rec'd by: ______________________________ Date: ____________________

Medication rec'd by: ______________________________ Date: ____________________

Medication brought in by: ______________________________ Date: ____________________

Medication brought in by: ______________________________ Date: ____________________

Medication picked up by: ______________________________ Date ____________________

Care Plan Reviewed:

RN Signature______________________________ Date: ____________________