Bee Sting Allergy History

Student name: _____ Date of Birth: _____
ID # _____ Grade _____ School _____
Parent/Guardian Name(s) _____
Mother Telephone Home _____ Cell _____ Work _____
Father Telephone Home _____ Cell _____ Work _____
Emergency Contact _____ Relationship to student _____
Telephone Home _____ Cell _____ Work _____
Health Care Provider Telephone # _____

1. Is your child's allergy considered life threatening?
   ☐ No ☐ Yes If yes, by State Law, your child may not attend school until the health care provider orders for this condition have been provided. **Please contact the School Nurse.**
2. Does your child have asthma? ☐ No ☐ Yes
3. Does your child have any other health condition(s) or medication allergies we should be aware of?
   ☐No ☐Yes, explain _____
4. When was your child last stung? _____
5. Describe how your child reacts to a bee sting.
   ☐ Local swelling ☐ Hives ☐ Difficulty Breathing ☐ Other _____
6. Has your child received medical care because of a bee sting?
   ☐No ☐Yes Health Care Provider Name _____
   Approximate Date _____
7. How do you usually treat a bee sting at home?

   _____
   _____
   _____

8. Does your child require medication at school for allergies to bee stings? ☐No ☐Yes, list medications below.

Medication Name	Amount	When to Use

9. This is our bee sting allergy health plan. If you want us to follow a different plan, please have your health care provider write specific orders.

Call 911 for help if:
- EpiPen is used
- Symptoms of allergic reaction develop
- Parent/student request 911
- Doctor's orders state 911 to be called

_____ _____
Signature of Parent/Guardian Date

RETURN TO SCHOOL NURSE

Allergy Action Plan

Student Name: _____ Birth Date: _____
School: _____ Grade: _____ Teacher: _____

Place Student Photo Here

ALLERGIC TO THESE ALLERGENS: _____

☐ **Has Asthma** (increases risk for severe reaction)

☐ **Severe Allergy previously/suspected—Immediately give epinephrine & call 911– Start with Steps 2 & 3**

☐ **Mild Allergy** – Itching, rash, hives – **Give antihistamine, call school nurse and parent. Start with Step 1**

► STEP 1: IDENTIFICATION OF SYMPTOMS* ◄

*** Send for immediate adult assistance**

Symptoms:		**Type of Medication to Give:** (Determined by physician authorizing treatment)	
➢	If exposed to allergen, or allergen ingested, but ***no symptoms***	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Mouth –**	Itching, tingling, or swelling of lips, tongue, mouth	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Skin –**	Hives, itchy rash, swelling of the face or extremities	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Gut –**	Nausea, abdominal cramps, vomiting, diarrhea	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Throat –**	Tightening of throat, hoarseness, hacking cough	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Lung** –**	Shortness of breath, repetitive coughing, wheezing	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Heart** –**	Faint, pale, blueness around mouth or nail beds, weak pulse, low B/P. .	☐ **Epinephrine**	☐ **Antihistamine**
➢ **Other** –**	_____	☐ **Epinephrine**	☐ **Antihistamine**
➢	If reaction is progressing (several of the above areas affected) give	☐ **Epinephrine**	☐ **Antihistamine**

**** Potentially life-threatening.** – Note: The severity of symptoms can quickly change.

► STEP 2: GIVE MEDICATIONS ◄

(Twinject™ NOT Recommended for School Use)

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® ☐ EpiPen Jr® ☐ Twinject™ 0.3 mg ☐ Twinject™ 0.15 mg

- **If Epinephrine is given, paramedics must be called! PROCEED TO STEP 3 BELOW.**

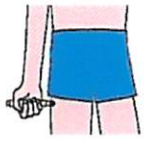
Antihistamine/other: give _____ *(Medication name & amount)* **by** _____ *(route/method)*

- **Notify** parents and school nurse • **Observe** for increasing severity of symptoms • **Call 911** as needed

IMPORTANT: Do NOT depend on asthma inhalers and/or antihistamines to replace epinephrine in a severe reaction.

EpiPen Directions:

a. Pull off the GRAY Safety Cap
b. Place BLACK TIP near OUTER-UPPER THIGH
c. Swing and jab firmly until hearing or feeling a click
d. Hold EpiPen in place **10 SECONDS**, remove, massage area
e. Dispose of in red sharps container or give to paramedics



- The EpiPen can be injected through clothing.
- The individual may feel his/her heart pounding.
  - This is a normal reaction to the medication.

► STEP 3: EMERGENCY CALLS ◄

1. **CALL 911** – *Seek emergency care.* State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call School Nurse
3. Call Parents or Emergency Contacts

Parent completes Parent and Emergency Contact Names and Information below:

Parents/Emergency Contact *Names*:	*Relationship:*	*Phone Number(s):*
a. _____	1.) _____	2.) ( ) _____ ( ) _____
b. _____	1.) _____	2.) ( ) _____ ( ) _____

Parent/Guardian Signature _____ Date _____
(Required)

Physician completes form through Step 2

Physician Name (Printed) _____ Phone Number: ( ) _____

Physician Signature _____ Date: _____
(Required)

This form must be renewed annually or with any change in medication.

The *Medication Administration Form* must be completed in addition to this *Allergy Action Plan*

School Phone # _____
School Fax # _____

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

Student Name: _____ **Date of Birth:** _____

PHYSICIAN USE ONLY

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ ***Date:*** _____

Physician Name: _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Parent Request
For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school. ***Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.***

Student Name: _____ **Date of Birth:** _____

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

B. For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: _____ ***Date:*** _____

Parent Signature: _____ ***Date:*** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307
(760) 552-6700 • (760) 242-5363 FAX

Authorization for Use and/or Disclosure of Information

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

School Site: _____ LEA of Residence: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

AUTHORIZATION

I authorize the individual/agency named below to disclose the above-named student's medical and/or educational information to the receiving LEA as indicated under this Authorization.

DISCLOSING AGENCY

Individual/Agency DISCLOSING Information: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ E-mail Address: _____

RECEIVING AGENCY

Individual/Agency RECEIVING Information: Victor Valley Union High School District

Street Address: 16350 Mojave Drive City: Victorville State: Ca Zip Code: 92395

Contact Name: Julie Dieppa, RN Phone: 760-955-3201 Ext. 10427 E-mail Address: jdieppa@vvuhsd.org

☐ **I agree that the Individuals/Agencies above may mutually share information.**

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

_____ **REVOCATION:** I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this Authorization.

_____ **REDISCLOSURE:** I understand that educational health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the receipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

_____ **HEALTH INFORMATION:** I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to assure medical treatment.

SPECIFY RECORD(s):

☐ Medical/Medication ☐ Mental Health/Psychiatric ☐ Drug/Alcohol
☐ Educational Records ☐ STD/HIV Test Results ☐ Other: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (Date)
or for one year from the date of signature if no date is entered.

I request that the information released pursuant to this Authorization be used for the following purposes:

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: _____ Date: _____

Student Signature: *(if applicable)* _____ Date: _____