

**VISTA UNIFIED SCHOOL DISTRICT
EMERGENCY HEALTH CARE PLAN AND MEDICAL AUTHORIZATION**

ALLERGIC REACTION TO _____

Student: _____ **DOB:** _____ **Grade:** _____
Weight: _____ **Date Weighed:** _____ **School:** _____ **Teacher:** _____
Parent: _____ **Phone:** _____

FOR MILD ALLERGIC REACTION

<i>Symptoms</i>	<i>What to Do</i>
<ul style="list-style-type: none"> • Several hives • Itchy skin • Swelling at site if an insect sting or bite • _____ • _____ 	<ul style="list-style-type: none"> • Student must be accompanied to health office. • Give _____ orally Antihistamine/Dose • Stay with student • Keep student quiet • Monitor symptoms _____ • Contact parent

In some cases, symptoms may progress to a life threatening reaction.

FOR SEVERE ALLERGIC REACTION

<i>Symptoms</i>	<i>What to Do</i>
<ul style="list-style-type: none"> • Hives spreading over the body • Wheezing • Difficulty swallowing or breathing • Swelling of face or neck • Tingling/swelling of tongue • Vomiting • Shock <ul style="list-style-type: none"> • Pale/gray color • Clammy skin • Weak • Loss of consciousness 	<ul style="list-style-type: none"> • Administer EpiPen* <ul style="list-style-type: none"> <input type="checkbox"/> EpiPen (Physician, Please check appropriate one). <input type="checkbox"/> EpiPen Jr. • Call 911 immediately. (EpiPen only lasts 20 – 30 minutes. Always call paramedics!) • Contact parents or other emergency contact • Also give _____ orally Antihistamine/Dose/Time • Stay with student • Keep student quiet • Monitor Symptoms

- **Indicate here if student is capable of carrying/using own Epi-Pen.** Yes No
- **Location of EpiPen:** Locked med cabinet in Health Office Backpack
 Other _____

***Directions for use of EpiPen:**

1. Pull off grey cap
2. Place black tip against upper outer thigh
3. Press hard into outer thigh until it clicks
4. Hold in place for ten seconds, then remove
5. Discard EpiPen in impermeable container and dispose of per school policy or give to emergency responder. (Do Not Return to Holder).

<p>For School use only when medication(s) are used.</p> <p><input type="checkbox"/> _____ mg. given po @ _____ AM/PM</p> <p><input type="checkbox"/> EpiPen given @ _____ AM/PM (Circle AM or PM)</p> <p><input type="checkbox"/> EpiPen Jr. given @ _____ AM/PM (Circle AM or PM)</p>	<p>Signed _____</p> <p>Date _____</p>
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Physician's Signature: _____ **Print Name:** _____
Phone Number: _____ **Fax Number:** _____ **Date:** _____
Physician's License # _____

School Nurse: _____ **Date:** _____

VISTA UNIFIED SCHOOL DISTRICT AUTHORIZATION FOR MEDICATION ADMINISTRATION
(Education Code Section 49423)

Any pupil who is required to take, during the regular school day, medication prescribed for him by a health care provider, may be assisted by the school nurse or other designated school personnel if the school district receives:

- 1) A written statement from such health care provider detailing the method, amount, and time schedules by which such medication is to be taken. *See the reverse side of this form.*
- 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 health care provider's statement. *See authorization statement below.*

This authorization is valid only for the current school year. If any of the conditions in the health care provider's statement change, parent/guardian must notify the school nurse and a new form must be signed by the parent/guardian and the provider. The parent/guardian may submit a written statement rescinding consent for administration of medication at school at any time. Parent/guardian will inform the school nurse of any changes in the student's health status or health care provider.

Only medication prescribed by the pupil's authorized health care provider as being necessary to be taken by the pupil in the manner listed on the provider's statement should be brought to school. Medication should be in original containers which are clearly marked with the name of the pupil, the name of the medication, and the amount of the medication.

This portion to be completed by the parent/guardian.

I request that a school nurse or other district designee administer the medication as directed by the health care provider on the reverse side of this form to my child:

Pupil's Name

I recognize the fact that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

I consent for the school nurse or site administrator to communicate with the authorized health care provider and pharmacist with regard to the provider's written statement for administration of medication at school.

Signature of Parent/Guardian

Date

Work Telephone Number/Home Telephone Number

DISTRITO ESCOLAR UNIFICADO DE VISTA AUTORIZACIÓN PARA ADMINISTRAR MEDICAMENTOS
(Sección 49423 del Código de Educación)

Cualquier alumno(a) que necesite tomar, durante el día escolar, un medicamento recetado por un médico para él/ella, puede ser asistido(a) por una enfermera escolar u otro empleado escolar designado si el distrito escolar recibe:

- 1) Una declaración escrita de dicho medico detallando el método, cantidad y horario a seguir para administrar dicho medicamento. *Refiérase al la parte de atrás de este formulario.*
- 2) Una declaración escrita de parte de los padres o tutores del alumno indicando que desean que el distrito escolar asista al alumno(a) a llevar a cabo lo indicado en la declaración médica. *Refiérase a la declaración de autorización a continuación.*

Esta autorización únicamente es válida durante el presente año escolar. Si algunas de las condiciones contenidas en la Declaración Médica cambian, un formulario nuevo debe ser firmado por los padres/tutores y el medico.

Únicamente los medicamentos que el medico le prescribió al alumno que se necesitan administrar al alumno de la manera enumerada en la Declaración Médica deben traerse a la escuela. El medicamento debe estar dentro de un envase que esté identificado con el nombre del alumno, nombre del doctor que prescribe el medicamento, y la cantidad del medicamento.

Esta parte debe ser llenada por los padres/tutores.

Yo solicito que una enfermera escolar u otro representante del distrito, le administer a mi hijo(a) el medicamento según las instrucciones del medico, contenidas en la parte de atrás de esta hoja:

Nombre del alumno

Yo reconozco el hecho de que este es un servicio o favor que la escuela no tiene que realizar legalmente. Yo estoy de acuerdo con mantener al distrito, sus oficiales, empleados o agentes, libres de cualquier responsabilidad, demandas o quejas de cualquier naturaleza o especie, que puedan suscitarse como resultado de la administración del medicamento conforme a esta solicitud.

Firma de los padres/tutores

Fecha Número de teléfono