Simi Valley Schools
SIMI VALLEY UNIFIED SCHOOL DISTRICT
Sean Goldman,
Assistant Superintendent,
Student Support Services

Board of Education
Sofya Bagdasaryan, President
Bob LaBelle, Clerk
Kareem Jubran
Kristina Pine
Dawn Smollen

Dear Parents & Guardians:

Our records indicate that your child has a food or other severe allergy. If you feel your child's allergies will require medication to be kept at school, the enclosed forms need to be completed and returned prior to the start of next school year.

Please complete the forms listed below:

- ***Allergy Health Record Update*** – To be completed by parent and returned to school. Please complete even if medication is not needed at school. If allergies are no longer a problem, please indicate on this form.
- ***Allergy / Anaphylaxis Emergency Plan - Parent and Healthcare Provider Authorization***
  To be completed and signed by parent and physician.
- ***Emergency Care Standard Procedure Management of Anaphylaxis*** – For parent and physician review only. Does not need to be returned.
- ***Authorization for Medication Taken during School Hours*** – To be completed and signed by parent and physician. A separate medication form is required for each prescribed medication.

If you have any questions, please contact your school nurse. ***Please turn in these necessary forms on or before the first day of school.***

Sincerely,

Simi Valley Unified School Nurses

101 W Cochran Street • Simi Valley, CA 93065 • Telephone: 805-306-4500 Ext. 4302 • Fax: 805-520-6586
sean.goldman@simivalleyusd.org

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Estimados padres de familia y tutores legales:

Nuestro archivo indica que su hijo/a sufre de alergias a comida o sufre de otra clase de alergia grave. Si usted cree que su hijo/a necesita mantener medicina en la escuela para las alergias, usted debe llenar y entregar los formularios aquí adjuntos a la escuela antes de comenzar el ciclo escolar.

Por favor llene los formularios listados a continuación:

- ***Allergy Health Record Update (Actualización del registro de salud para alergias)*** – El padre de familia debe llenar y entregar este formulario a la escuela. Por favor llénelo aunque no necesite medicina en la escuela. Si ya no tiene problemas con las alergias, por favor márquelo en este formulario.

- ***Allergy/Anaphylaxis Emergency Plan (Plan de Emergencia para Alergias / Anafilaxia) – Autorización del padre y del médico*** - El padre de familia y el médico deben llenar y firmar este formulario.

- ***Management of Anaphylaxis – Emergency Care Standard Procedure (Información para el Manejo de Anafilaxia*** – Formulario C) – Solamente para que lo revise el padre de familia y el médico. No necesita devolverlo.

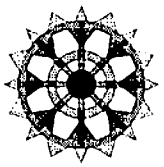
- ***Authorization for Medication Taken During School Hours (Autorización para tomar medicina durante el horario escolar)*** – El padre de familia y el médico deben llenar y firmar este formulario. Se necesita un formulario por separado para cada medicina recetada.

Si usted tiene alguna pregunta, por favor comuníquese con la enfermera de la escuela. *Por favor entregue estos formularios antes o durante el primer día de clases.*

Atentamente,

Enfermeras del Distrito Escolar Unificado de Simi Valley

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SimiValleySchools

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ALLERGY HEALTH RECORD UPDATE

Student _____ Date of Birth _____ School _____ Grade _____

Name of Physician: _____ Phone: _____

☐ Allergies are no longer an active problem for my child. Please update this information on my child's school record.

Current allergies include:

☐ Nuts (Please specify) _____

☐ Foods (Please specify) _____

☐ Bee stings _____

☐ Other (Please specify)_____

Symptoms my child experiences (check all that apply):

☐ Apprehension/anxiety or sense of doom	☐ Throat tightness	☐ Hacking/repetitive coughing	
☐ Difficulty swallowing	☐ Wheezing	☐ Red, watery eyes	☐ Sneezing
☐ Short of breath/difficulty breathing	☐ Swelling	☐ Change of voice	☐ Itching
☐ Change of skin color (pale, blue)	☐ Diarrhea	☐ Rash	☐ Hives
☐ Fainting or loss of consciousness	☐ Nausea	☐ Vomiting	☐ Dizziness

☐ Other _____

History (allergy reactions): ☐ Has used Epi-pen ☐ Has called 911/Ambulance ☐ Has been hospitalized

Plan for care at school:

☐ No medication required – standard first aid only

☐ Benadryl (Diphenhydramine) - **Medication Authorization Form required**

☐ Epi-pen - **Medication Authorization Form required**

☐ Peanut-aware table required for snack/lunch

☐ Other _____

Person completing this form _____

Parent/Guardian Signature _____ Date _____

Please return this update, along with any medications and authorization forms to the school office.

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ALLERGY/ANAPHYLAXIS EMERGENCY PLAN

Name: _____ DOB: _____ School: _____

Allergy to: _____ Asthma: ☐ Yes ☐ No

MILD SYMPTOMS ONLY:

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

1. **GIVE ANTIHISTAMINE**
2. Stay with student and monitor.
3. Contact parent and school nurse.
4. If symptoms progress (see below), **USE EPINEPHRINE**

Extremely reactive to the following foods / allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately for **ANY** symptoms after ***likely*** exposure to allergen.

☐ If checked, give epinephrine immediately if student has ***definite*** exposure to allergen, even if no immediate symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion / exposure:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (eyes, lips)
GUT:	Vomiting, diarrhea, cramps, pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911.
3. Monitor breathing and airway.
4. Administer antihistamine / inhaler after epinephrine if prescribed below.
5. Lay student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
6. Give second dose of epinephrine if symptoms persist or reoccur (5 minutes or more after last dose) if prescribed.
7. Contact parent and school nurse.

Medications/Dosage

Antihistamine (brand and dosage): _____

Epinephrine (brand and dosage): _____

☐ Administer 2nd dose of epinephrine ____ minutes after 1st dose if symptoms persist or reoccur.

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Parent Consent for Authorization and Management of Anaphylaxis in School Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above named student, request that the specialized physical healthcare service, anaphylaxis treatment, be administered to my (our) child in accordance with state laws and regulations. I (we) give consent for the school nurse to communicate with the authorized healthcare provider.

Parent(s)/Guardian(s) Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Address:** _____ **Phone:** _____

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Emergency Care Standard Procedure – Management of Anaphylaxis

Pupil:	DOB:	Date:
School:	Teacher/Rm:	Grade

Purpose:	1. To counteract the adverse reaction to an allergen. 2. To provide immediate treatment and access to emergency medical care. 3. To provide cardiopulmonary resuscitation (CPR) if needed.

PROCEDURES

Essential Steps	Key Points and Precautions
1. Determine whether the pupil has signs or symptoms of anaphylaxis. **When in doubt, treat for anaphylaxis** * **Mouth:** Itching, tingling or swelling of lips, tongue, mouth * **Skin:** Itching or burning, hives, rash, swelling of face or extremities, flushing * **Stomach:** Nausea, abdominal cramps, vomiting, diarrhea * **Throat:** Tightening of throat, hoarseness or change of voice, hacking or repetitive cough * **Lung:** Shortness of breath, wheezing, chest pain/tightness, nasal flaring, or complaints of not being able to "catch my breath" * **Heart:** Weak or thready pulse, low blood pressure, paleness, blueness, general body weakness, dizziness, fainting/unconsciousness * **Other:** Localized or general body swelling, apprehension/anxiety, red/itchy/watery eyes, excessive sneezing, nasal congestion	1. Stay with pupil. Remain calm and reassure pupil. Calming reduces the distribution of the allergen in the body. Anaphylaxis usually occurs in 5-10 minutes after exposure to the allergen – an insect sting, ingestion of a medication, contact with latex product or food (consumption or contact), such as peanuts, eggs, fish, tree nuts or milk. Reactions can be delayed for up to <u>two</u> hours after exposure. <u>Any food, medication or insect sting can potentially cause a reaction.</u> Additional information: _____ _____
2. SUMMON HELP Direct helper to call 911 emergency services immediately. Report that epinephrine was given. Request ambulance with epinephrine. Prepare to administer epinephrine auto-injector.	2. **Direct others to call the school nurse, parent and site administrator.** School nurse or parent will notify the physician.
3. Wash hands and put on disposable gloves if doing so will not delay emergency treatment.	3. Standard Precautions prevent infection.

Emergency Care Standard Procedure – Management of Anaphylaxis

Pupil:	DOB:	Date:
4. Administer the prescribed medication according to the attached healthcare provider's authorization. Injection may be given through clothing if necessary. Refer to specific directions for auto-injector. * Pull off safety cap. * Place tip on outer thigh. * Push auto-injector firmly against thigh until unit activates. * Hold in place 10 seconds (count to 10 slowly). Carefully place used auto-injector back in carrying tube. Avoid needle stick if needle exposed. * Note time epinephrine was given.	4. Simple directions are printed on the auto-injector tube. Follow additional specific instructions for pupil. Pupil may be given 2nd dose of epinephrine by auto-injector if symptoms persist or reoccur, or if there are physician orders for student. Other: _____	
5. When administering epinephrine via auto-injector, follow these precautions: * Never put thumb, fingers or hand over tip of auto-injector. * Do not remove safety cap release until ready to use auto-injector. * Accidental injection into the hand or foot may result in loss of blood flow to the area.	*If reaction is due to an insect sting, remove the stinger as soon as possible after administering epinephrine. Remove stinger by scraping with a fingernail, plastic card or cardboard. **DO NOT** push, pinch or squeeze the sting area. Such action may cause more venom to be released into pupil's body.	
6. While waiting for paramedics to arrive, stay with pupil and observe for signs of shock. Verify that 911 emergency services have been called. * Monitor breathing and maintain body temperature. Provide CPR if needed. * Administer a second dose of epinephrine according to healthcare provider's directions. A second dose may also be given if symptoms reoccur.	6. Monitor pupil. * Cover pupil with blanket as needed to maintain body temperature and prevent shock. * After receiving epinephrine, pupil may feel his/her heart pounding. This is a normal reaction to the medication. * Epinephrine acts immediately, but the effects last only 15-20 minutes.	
7. Paramedics may administer additional epinephrine when they arrive. <u>Give paramedics the expended auto-injector</u> and all information regarding exposure to allergen and pupil's reaction.	7. Send the following information with the pupil being transported by paramedics: name, dose, route, time(s) of medication administration, and parent contact information if parent not present. School nurse or administrator should accompany pupil to Emergency Room and remain until parent arrives. Report / document outcome to the site administrator, school nurse and parents.	

NOTE TO PHYSICIAN: If there are any changes/additions to the above procedures, please mark and initial changes/additions to this form and sign below.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Address:** _____ **Phone:** _____

AUTHORIZATION FOR ALL MEDICATIONS TAKEN DURING SCHOOL HOURS, SCHOOL ACTIVITIES AND FIELD TRIPS

This form must be completed at least annually and more frequently if the prescription changes in any way or as designated in the Individual Education Program (IEP) or in the Rehabilitation Act, Section 504 Plan.

PARENT OR LEGAL GUARDIAN

1. Parent or Legal Guardian Section

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician or other licensed health care provider (LHCP). Please refer to Legal References Governing the Administration of Medication in Schools on the reverse side of this form.

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication(s) (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse to communicate with my child's prescriber and/or the pharmacist and to counsel school personnel as needed with regard to my child's health. I agree to comply with local educational agency policies and regulations related to administering medication at school.

Name of Child	Birth Date	Student Identification Number
Name of School	Grade	Teacher/Room Number

List all medications routinely taken outside of school hours: _____

I will immediately notify the school if there are any changes in medications my child is taking at school.

☐ If ordered by a LHCP, I give consent for my child to self-administer emergency medication at school. I agree to and do hereby release and hold the local educational agency and its governing board, officers, agents, employees and volunteers harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of self-administration of the medication(s).

Signature of Parent or Legal Guardian	Date	Primary Telephone	Alternate Telephone

Licensed Health Care Provider

2. Licensed Health Care Provider Section

The child named above is under my care for these diagnoses: _____

It is necessary for the child to receive the following prescribed medication(s) during school hours.

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____
Storage and handling
☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child *to carry* prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____
Storage and handling
☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child *to carry* prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____
Storage and handling
☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child *to carry* prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Stamp LHCP name/address below:

Signature of LHCP or Supervising Physician	Date
Name of LHCP (please print)	License Number / Office telephone

Copy –Local Educational Agency
SFA 5030, Rev. 10/19/2021

Copy – Parent or Legal Guardian

Copy –Licensed Health Care Provider

AUTORIZACIÓN PARA TODO MEDICAMENTO TOMADO DURANTE HORAS ESCOLARES, ACTIVIDADES ESCOLARES, Y XCURSIONES

Este formulario debe completarse al menos una vez al año y con mayor frecuencia si la receta cambia de alguna manera o como indicado en el Programa Educativo Individualizado (IEP por sus siglas en inglés) o en la Sección de la Ley de rehabilitación Plan 504.

PADRE O TUTOR LEGAL

1. Sección de padre o tutor legal

AVISO: Todos los medicamentos deben ser recetados, **incluso los medicamentos a venta libre.** Los medicamentos deben estar en su recipiente/frasco original y la etiqueta debe llevar el nombre del niño, el nombre del medicamento, la dosis, la forma de administración, el horario de tomar la medicina y el nombre del médico u otro proveedor de atención médica autorizado (LHCP por sus siglas en inglés). Por favor, consulte las Referencias legales que rigen la administración de medicamentos en las escuelas en el reverso de este formulario.

Solicito que el personal escolar designado, sin licencia y capacitado, o la enfermera con licencia, ayuden a mi hijo a tomar esta(s) medicación(es) recetada(s) (incluyendo la medicación recetada de venta libre). Entiendo que mi hijo no puede ser asistido con la medicación en la escuela hasta que se cumplan todos los requisitos. Por la presente doy mi consentimiento para que la enfermera de la escuela se comunique con el médico prescriptor de mi hijo y/o con el farmacéutico y para que asesore al personal de la escuela según sea necesario con respecto a la salud de mi hijo. Estoy de acuerdo en cumplir con las políticas y regulaciones de la agencia educativa local relacionadas con la administración de medicamentos en la escuela.

Nombre del niño	Fecha de nacimiento	Núm. de Identificación
Nombre de la Escuela	Grado	Maestro / No. de Salón de Clase

Apunte todos los medicamentos que se tomen con regularidad fuera de las horas escolares: _____

Avisaré a la escuela inmediatamente si hay cambios de cualquier tipo en los medicamentos que mi hijo toma en la escuela.

☐ Si lo ordena un LHCP, doy mi consentimiento para que mi hijo se auto administre medicamentos de emergencia en la escuela. Estoy de acuerdo y por la presente libero y eximo de responsabilidad a la agencia educativa local y a su consejo directivo, funcionarios, agentes, empleados y voluntarios por cualquier reclamo, demanda, causa de acción, responsabilidad o pérdida de cualquier tipo, debido a la autoadministración de los medicamentos o que surja de ella

Firma del Padre o Tutor Legal	Fecha	Teléfono principal	Teléfono alternativo

PROVEEDOR DE SERVICIOS DE SALUD LICENCIADO

2. Sección de proveedores de servicios de salud autorizados

El niño nombrado arriba está bajo mi cuidado por estos diagnósticos: _____

Es necesario que el niño reciba los siguientes medicamentos recetados durante el horario escolar.

Nombre of medicamento _____ Dosis (sea especifico, p.ej. miligramos, etc.) _____
Hora de administración _____ Frecuencia e indicación si es "según necesidad" _____
Método de administración _____ Duración _____
Precauciones o efectos secundarios _____
Almacenamiento y manipulación

- ☐ Manejo rutinario, el medicamento se almacena bajo llave y es administrado por personal escolar autorizado
- ☐ Suministro de 72 horas en caso de catástrofe
- ☐ Es una *Necesidad médica* que el niño *lleve* una receta para el asma, anafilaxia o la diabetes, e indicar:
  - ☐ Personal escolar designado para administrar
  - ☐ El niño está capacitado para auto administrarse

Nombre of medicamento _____ Dosis (sea especifico, p.ej. miligramos, etc.) _____
Hora de administración _____ Frecuencia e indicación si es "según necesidad" _____
Método de administración _____ Duración _____
Precauciones o efectos secundarios _____
Almacenamiento y manipulación

- ☐ Manejo rutinario, el medicamento se almacena bajo llave y es administrado por personal escolar autorizado
- ☐ Suministro de 72 horas en caso de catástrofe solo en la escuela
- ☐ Es una *Necesidad médica* que el niño lleve una receta para el asma, anafilaxia o la diabetes, e indicar:
  - ☐ Personal escolar designado para administrar
  - ☐ El niño está capacitado para auto administrarse

Nombre of medicamento _____ Dosis (sea especifico, p.ej. miligramos, etc.) _____
Hora de administración _____ Frecuencia e indicación si es "según necesidad" _____
Método de administración _____ Duración _____
Precauciones o efectos secundarios _____
Almacenamiento y manipulación

- ☐ Manejo rutinario, el medicamento se almacena bajo llave y es administrado por personal escolar autorizado
- ☐ Suministro de 72 horas en caso de catástrofe solo en la escuela
- ☐ Es una *Necesidad médica* que el niño lleve una receta para el asma, anafilaxia o la diabetes, e indicar:
  - ☐ Personal escolar designado para administrar
  - ☐ El niño está capacitado para auto administrarse

Sello LHCP
nombre/dirección abajo:

Firma del LHCP o médico supervisor	Fecha
Nombre del LHCP (imprimir) / Número de licencia	Nº de teléfono de la oficina

LEGAL REFERENCES GOVERNING THE ADMINISTRATION OF MEDICATION IN SCHOOLS

California *Business and Professions Code.*

Health Care Providers licensed to prescribe medication include:

Section 2051, California licensed physicians and surgeons

Section 1625, California licensed dentists

Section 3041, California licensed optometrists

Section 2472, California licensed podiatrists

Section 2836.1, California licensed nurse practitioners

Section 2746.51, California-certified nurse midwives

Section 3502.1, California licensed physician assistants

California *Education Code.*

Section 33031, State Board of Education adopt rules and regulations

Section 49423, Auto-injectable epinephrine, assistance at school or carry and self-administer

Section 49423.1, Inhaled asthma medication, assistance at school or carry and self-administer

Section 49423.6, Regulations regarding administration of medication in public schools

NOTE: California *Education Code* 49423.5, specialized physical health care services, i.e., catheterization, gastric tube feeding, suctioning, or other services that require medically related training, may require additional forms and instructions signed by parent or legal guardian and physician. Request *Specialized Services* forms from school.

California Code of Regulations, Title 5, Education.

Section 601, Definitions

(a) Authorized health care provider
(b) Medication
(c) Medication Log
(d) Medication Record
(e) Other designated school personnel
(f) Parent or legal guardian
(g) Regular school day
(h) School nurse

Section 602, Written Statement of Authorized Health Care Provider.

Section 603, Written Statement of the Parent or Legal Guardian.

Section 604, Administration of Medication to Pupils or Otherwise Assisting Pupils in the Administration of Medication.

Section 605, Self-Administration of Medication.

Local Educational Agency Policies

Board Policy 5141.21, Administering Medication and Monitoring Health Conditions

Administrative Regulation 5141.21, Administering Medication and Monitoring Health Conditions