



OCEAN VIEW SCHOOL DISTRICT
Student Services/Health Services



Questionnaire for Parents of Child with Bee Sting/Other Insect Bite Allergy

Please print:

School Year: _____ Date: _____
 Student Name: _____ Birth Date: _____ Grade: _____
 Parent Name: _____ Home #: _____ Work #: _____
 Physician Name: _____ Telephone: _____

You have notified the school that your child has a bee sting or other insect bite allergy. The following information will be helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer to the best of your ability and return this form to the school office. Thank you!

Nurse's Name: _____ Telephone: _____
 School Fax: _____

1. Approximate date of last sting or bite: _____
2. Description of reaction: _____
3. Was your child treated by a doctor or hospital for this? Yes No
4. Has your child undergone desensitization injections? Yes No
5. Do you have medication at home to give in case of bite/sting? Yes No
 If yes, name of medication: _____ Dosage: _____
6. Was medication prescribed by a doctor? Yes No

If your doctor has recommended medication be given immediately in case of an allergic reaction, a supply of medication can be kept and given at school for emergency use. If you wish to arrange for this, please contact the school nurse.



OCEAN VIEW SCHOOL DISTRICT
Huntington Beach, California



Severe Allergy Action Plan

Student's name _____ DOB _____ Teacher _____

ALLERGY TO: _____ Asthmatic? (Circle one) Yes No

STEP 1: TREATMENT

Symptoms:

- ❖ If a food allergen has been ingested, but *no symptoms*:
- ❖ Mouth – Itching, tingling, or swelling of lips, tongue, mouth
- ❖ Skin – Hives, itchy rash, swelling of the face or extremities
- ❖ Gut – Nausea, abdominal cramps, vomiting, diarrhea
- ❖ Throat† - Tightening of throat, hoarseness, hacking cough
- ❖ Lung† - Shortness of breath, repetitive coughing, wheezing
- ❖ Heart† - Thready pulse, low blood pressure, fainting, pale, blueness

Give Checked Medication**

(To be determined by physician authorizing treatment)

- | | |
|-----------------------------------|-------------------------------------|
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |
| <input type="radio"/> Epinephrine | <input type="radio"/> Antihistamine |

The severity of symptoms can quickly change. † Denotes potentially life-threatening.

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Other: _____

Antihistamine: give _____
(Name of Medication) (Dosage) (Route)

Other: give _____
(Name of Medication) (Dosage) (Route)

STEP 2: EMERGENCY CALLS

1. Call 9-1-1. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Parents: _____
(Mother's Name) (Phone number during school hours) (Cell number)

3. Parents: _____
(Father's Name) (Phone number during school hours) (Cell number)

4. Physician: _____ Office Number: _____

Parent/Guardian Signature: _____ Date _____



PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Name of Student: Birth date: Grade/Track: School/District: Teachers Name:

California Education Code Section, 49423.5 allows the school nurse to train monitor and supervise non-medical school personnel to assist students who require treatment during the school day.

I request that the following treatment(s) be administered to my child as ordered by the authorized health care provider:

I understand that designated non-medical school personnel will administer treatment under supervision of a qualified School Nurse. I will notify the school immediately and submit a new authorization form if there are ANY changes in the treatment and/or prescribing authorized health care provider.

Parent/Guardian Signature: Date:

Telephone: (Work) (Home) (Other)

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Treatment: Emergency Treatment of Allergic Reactions and Anaphylactic Shock

Time schedule and/or indication:

Precautions, possible untoward reactions, and recommend intervention(s):

Nursing practice standards will be used for the above stated treatment UNLESS there are specific modifications or recommendations needed as checked below:

() a. Implement the treatment using nursing practice standards along with the following modifications:

() b. Implement the treatment using nursing practice standards along with my attached recommendations.

Authorized Health Care Provider Signature:

Provider NPI#:

Telephone:

Date of Request:

Date to Discontinue Treatment:



Office Stamp

SCHOOL USE:

Reviewed by: Date:

This request is valid for a maximum of one year.



EMERGENCY TREATMENT OF ALLERGIC REACTIONS AND ANAPHYLACTIC SHOCK

<p>ALLERGEN Please Specify</p> <hr style="width: 50%; margin: 20px auto;"/>
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I. GENERAL INFORMATION

To recognize and relieve symptoms of allergic reactions.

- A. Purpose: To recognize and relieve symptoms of allergic reactions.
- B. Average allergic reaction is a hypersensitive state to a foreign substance (allergen), such as insect sting venom, certain foods, chemicals or drugs.
- B. Reactions may range from mild to life-threatening anaphylactic shock. Delayed reactions, such as joint pain, achiness, and localized redness and warmth may occur a few days later.

C. Signs and symptoms may include:

<u>Mild</u>	<u>Moderate/Severe</u>	<u>Anaphylactic Shock</u>
Localized: Pain	Generalized, intense itching	Agitation
Itching	Dizziness	Difficulty breathing --
Swelling	Headache	(Swelling of the throat)
Redness	Nausea	Cyanosis
	Hives	Throbbing heart beat
	Abdominal cramps	Convulsions
		Unconsciousness

- D. Anaphylactic shock is serious and can be fatal. It may occur within 5 minutes to 1 hour after exposure to the allergen. Emergency action is imperative to prevent severe complications or death.
- E. Since injections are involved in the management of anaphylactic shock, the adoption of a policy of giving injections by personnel other than nurses is left to the discretion of each school district or county office. A pre-filled, auto-injection method (such as EpiPen) is recommended for ease of administration.
- F. Parent/care provider to supply necessary equipment for performing procedure at school.

<p>b. Observe student for 20 – 25 minutes.</p> <ol style="list-style-type: none"> 1) If localized pain and itching subside or remain minimal, student may return to class. 2) If localized pain, itching and swelling increase, notify parent/care-provider. 3) If moderate or severe symptoms, or anaphylactic shock develops, continue as per procedure. <p>3. Manage Moderate/Severe Reactions:</p> <ol style="list-style-type: none"> a. If intense itching with hives occurs <u>without</u> progression to anaphylactic shock symptoms, then give oral/topical medication if prescribed by physician. This may be sufficient. b. Notify physician and parent/care-provider. <p>4. Manage Anaphylactic Shock</p> <ol style="list-style-type: none"> a. Administer oral medication if prescribed by physician. b. Administer intramuscular injectable medication immediately straight into the upper, outer thigh or top of arm. c. Call paramedics and notify parent/care-provider. d. Cover with blanket to maintain body temperature. <p>5. Document incident.</p>	<p>Be prepared to administer adrenalin, as <u>seconds</u> count!</p> <p>If at any time during procedure breathing stops INITIATE CPR IMMEDIATELY.</p> <p>These are large muscle groups commonly used for deep injections.</p>
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EMERGENCY TREATMENT OF ALLERGIC REACTIONS AND ANAPHYLACTIC SHOCK

Student's Name: _____ DOB: _____

Equipment and Supplies *(Responsibility of parent/care-provider).	<ol style="list-style-type: none"> 1. Oral and/or topical medications as prescribed by physician (Chlortrimeton, Benedryl, etc.) 2. * Emergency injection kit (Adrenalin/Epinephrine) 	<ol style="list-style-type: none"> 3. For insect stings/bites, add the following: <ul style="list-style-type: none"> • Antiseptic solution • Meat tenderizer, baking soda • Cold pack
PROCEDURE		
ESSENTIAL STEPS	KEY POINTS & PRECAUTIONS	
<ol style="list-style-type: none"> 1. Notify school nurse immediately. 2. Determine severity of allergic reaction and proceed accordingly: <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> For insect sting/bite, continue with Step #3; for all other allergic reactions, proceed DIRECTLY TO STEP #4, 5, or 6, depending on severity. </div> <p>Manage insect sting/bite If stinger is still in skin, scrap off with fingernail, fingernail file or tongue blade. DO NOT SQUEEZE STINGER.</p> <ol style="list-style-type: none"> a. Cleanse sting area with antiseptic solution and rinse well with cold water. b. Apply meat tenderizer or baking soda. c. Apply cold pack to sting area. 3. Manage Mild Reaction <ol style="list-style-type: none"> a. Apply cold pack, if appropriate. 	<p>Stinger may have venom sac attached. Squeezing may release more venom.</p> <p>Cleansing reduces chances of secondary infection.</p> <p>Venom contains protein elements that are broken down by meat tenderizer. Baking soda acts as a neutralizer.</p> <p>Cold reduces swelling. Wrap cold pack in toweling, Since direct application of ice can cause tissue damage.</p> <p>Cold reduces swelling. Wrap cold pack in toweling, since direct application of ice can cause tissue damage.</p>	
ESSENTIAL STEPS	KEY POINTS & PRECAUTIONS	



***PARENT NOTIFICATION FOR THE
ADMINISTRATION OF MEDICINE AT SCHOOL***

Name of Student: _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

**IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING
CONDITIONS MUST BE MET:**

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school.

This request is valid for a maximum of one year.



Orange County Department of Education
Community and Student Support Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birthdate: _____
School/District: _____ Teachers Name: _____ Grade/Track: _____

**PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION**

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: Epinephrine Auto-Injector Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

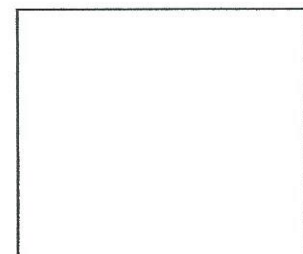
Authorized Health Care Provider Name (print clearly): _____

Telephone _____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication: _____



Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:

Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.



Orange County Department of Education
Community and Student Support Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: Birthdate: School/District: Teachers Name: Grade/Track:

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

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I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use.

Parent/Guardian Signature: Date: Telephone: (Work) (Home)

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication:

Medication: antihistamine Dose: Route: Time:

If PRN: Amount of time between doses Maximum number of doses

Possible medication reactions:

Instructions for emergency care

Authorized Health Care Provider Signature:

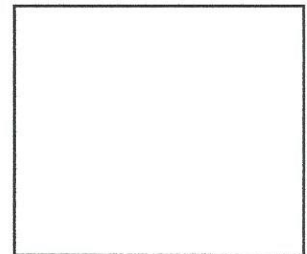
Authorized Health Care Provider Name (print clearly):

Telephone

Provider NPI #

Date of Request:

Date to Discontinue Medication:



Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials

SCHOOL USE:

Reviewed by: Date:

This request is valid for a maximum of one year.