ANGELA C. RADONSKI, BSN, RN
Nurse Administrator

Dear Parents,

A law has been enacted in Washington that requires children with life-threatening conditions to have a medication or treatment order on file prior to attending school. This law, called Substitute House Bill 2834, took effect on June 13, 2002.

The medication or treatment order must address the life-threatening condition and it must be on file with the school prior to the child attending school. Under the law, "life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition, our school nurses will be responsible for putting a nursing care plan in place. The law provides that a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to be provided at school.

Having reviewed the information you provided regarding your child's health, it appears that your child has a life-threatening condition that requires a medication or treatment order.

At the start of every school year, you will need new medication order forms filled out by your health care provider for the next school year to comply with Substitute House Bill 2834, commonly known as the "Life Threatening Condition" law. The following new forms are included for your convenience:

- Healthcare Provider Letter-Please print and give to Health Care Provider
- Bee or Insect Allergy Assessment Form
- Health Care Provider Epinephrine Request and Treatment Plan for Anaphylaxis (This needs to be completed by the health care provider and parent and then brought to the school before the first day of attendance at school with the medication).
- Medication Authorization Form

Please have your physician complete the **health care Provider Epinephrine Request and Treatment Plan for Anaphylaxis** and sign the parent permission portion of the form. Return this form to your child's school nurse as soon as possible.

Upon receipt of the information from your health care provider, the school nurse will contact you to develop an appropriate nursing plan. She will then need to train the staff. Your child may not be able to start school on the first day of school if the orders are not at school three days prior to school starting.

Sincerely,

Angela C. Radonski, BSN, RN

516 176th Street East • Spanaway, Washington 98387 • 253.800.2304 • aradonski@bethelsd.org

Dear Health Care Provider,

The state of Washington has published *guidelines for care of students with life-threatening allergies. The guidelines are comprehensive; however, the message to alert health care providers who prescribe emergency medications to be given at school to students who had a contact with an allergen is:

For students with a medical order to administer epinephrine at school to treat anaphylaxis or possible anaphylaxis, the recommended protocol after exposure is to immediately:

1. **Administer Epinephrine**
2. **Call 911**
3. **Call Parents**

Benadryl can no longer be administered first and there cannot be a "wait and watch" period of time. This change is necessary because:

1. Most schools do not have full time nurses in the building. Even if the nurse is in the district, it is impossible for the nurse to be on location at all times to provide an *accurate assessment of the student's health status.*

2. Unlicensed school staff (health clerks, secretaries, principals, teachers, coaches, bus drivers, etc.) will be the front line adults on site when the student has a contact to the specific allergen causing potential anaphylaxis.

3. **Unlicensed school staff members are unprepared to assess the student's health status to determine whether or not to administer epinephrine and/or when to administer it. *Registered nurses may not delegate assessment and clinical judgment to unlicensed school staff.***

4. For the safety of the student, epinephrine will be administered immediately as ordered by the health care provider.

Thank you for your assistance in implementing this requirement.

If you have any questions, please contact the school nurse.

**Guidelines for Care of Students with Anaphylaxis* available at http://www.k12.wa.us/HealthServices/Publications/09-0009.aspx

Bee or Insect Allergy Form

Student Name: ______________________________ Date of Birth: ______________

Parent/Guardian: ______________________ Phone: ____________ Cell/work: ____________

Health Care Provider (name) treating bee allergy: ______________________ Phone ____________

Do **you think** your student's bee allergy may be **life-threatening**? ☐ No ☐ Yes

(If YES, please see the school nurse as soon as possible.)

Does your student's **health care provider think** the bee allergy may be **life-threatening**? ☐ No ☐ Yes

(If YES, please see the school nurse as soon as possible.)

History and Current Status

What type of stinging bee or insect has your student reacted to? ______________________

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, please describe:

____

When was the last reaction? ______________

Are the reactions: ☐ staying the same ☐ getting worse ☐ getting better

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction? ☐ No ☐ Yes, please describe: ____

Has your student ever received or used an EpiPen® or other injection as treatment? ☐ No ☐ Yes, please describe: ____

Triggers and Symptoms

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things your child might say.)*

____

How quickly do the signs and symptoms appear after the sting? ___ seconds ___minutes ___ hours ___days

Treatment

Does your student understand how to avoid getting a bee sting or insect bite? ☐ Yes ☐ No

What do you do at home if there is a reaction to a bee sting or insect bite? ______________________

What treatment or medication has your health care provider recommended for an allergic reaction?

____ ☐ None

Have you used the treatment or medication? ☐ No ☐ Yes

Does your student know how to use the treatment or medication? ☐No ☐ Yes

Please describe any side effects or problems your student had in using the suggested treatment or medication.

____

If medication is to be available at school, have you filled out a medication form for school?

☐ Yes

☐ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication or treatment supplies to school?

☐ Yes

☐ No, I need to get the medication/treatment and bring it to school.

What do you want the school to do in case of a bee sting or insect bite? ______________________

Parent/Guardian Signature: ______________________ Date: ______________

Adapted with permission from ESD 171 SNC Program

Pierce County Medical Society

HEALTH CARE PROVIDER EPINEPHRINE REQUEST AND TREATMENT PLAN FOR ANAPHYLAXIS

School Year	School	Fax

Student Name: ______________________________ may require treatment to prevent/treat anaphylaxis.

Student is allergic to .

The symptoms of anaphylaxis may include breathing difficulty, facial/throat swelling or tingling, hives, rash, itching, stomach cramps, nausea/vomiting, dizziness, or swelling away from the site of a bee sting.

The treatment plan for preventing/treating anaphylaxis at school is as follows: (check all that apply)

If student is exposed to allergen and/or exhibits any symptom of anaphylaxis,

Give epinephrine IMMEDIATELY:

- ☐ Epinephrine auto-injector 0.3 mg
- ☐ Epinephrine auto-injector 0.15mg

Repeat dose of epinephrine may be given if ____

Call 911 at the time epinephrine is given and notify parent/guardian.

☐ **This student also has asthma and may be at higher risk for developing anaphylaxis.**

Student and parent/guardian have been instructed in use of epinephrine auto-injector. _____ Yes _____ No
Student may carry and self-administer the epinephrine auto-injector ordered above. _____ Yes _____ No

______________________________ Health Care Provider's Signature

______________________________ Health Care Provider's Printed Name or Stamp

____________ Telephone

____________ Fax

____________ Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, (name of child) ______________________, or allow my child to carry and self-administer as indicated above, the medication prescribed by (name of health care provider) ______________________ for the ______________ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

______________________ Parent/Guardian Signature

Work:	Cell:
Home:	Other:

____________ Date

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above.

School Nurse Signature: Date: