Bethel SCHOOLS

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 writing a nursing care plan and training staff prior to school starting. 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
- Food 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
- Diet Prescription for Meals at School

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

Upon receipt of the information from your healthcare 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,

School Nurse

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 <u>not</u> 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

Food Allergy Assessment Form

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

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating food allergy: _____ Phone: _____

Do **you think** your child's food allergy may be **life-threatening**? ☐ No ☐ Yes
(If YES, please see the school nurse as soon as possible).

Did your student's **health care provider tell you** the food allergy may be **life-threatening**? ☐ No ☐ Yes
(If YES, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

☐ Peanuts ☐ Fish/shellfish ☐ Eggs
☐ Peanut or nut butter ☐ Soy products ☐ Milk
☐ Peanut or nut oils ☐ Tree nuts (walnuts, almonds, pecans, etc.)
Please list any others: _____

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

_____

When was the last reaction? _____

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

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

☐ Eating foods ☐ Touching foods ☐ Smelling foods ☐ Other, please explain: _____

_____

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

_____

_____

How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____ Minutes _____ Hours _____ Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?
☐ No ☐ Yes, explain: _____
Does your student understand how to avoid foods that cause allergic reactions? ☐ Yes ☐ No

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

_____

_____

Have you used the treatment? ☐ No ☐ Yes

Adapted with permission from ESD 171 SNC

Does your student know how to use the treatment? ☐No ☐ Yes
Please describe any side effects or problems your child had in using the suggested treatment:_____
_____
_____

If you intend for your child to eat school provided meals, have you filled out a diet order 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 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/treatment supplies to school?

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

What do you want us to do at school to help your student avoid problem foods?_____
_____
_____

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

☐ Yes.
☐ No.

Parent/Guardian Signature:_____ Date: _____

Reviewed by R.N.: _____ 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.

_____ Work: Cell: _____
Parent/Guardian Signature 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:

Bethel Public Schools Nutrition Services
Diet Prescription for Meals at School

Student Name: _____Date of Birth: _____ Age: ____

Name of School: _____ Grade: _____

Section A: To be completed by parent or guardian. Please check box(es) and sign below:

☐ I understand that if my child's medical or health needs change, it is my respons bility to notify my child's school nurse/health clerk and have a new Diet Prescription for Meals at School form completed.

☐ I give Nutrition Services permission to speak with the Physician or Authorized Medical Authority named below to discuss the dietary needs described below.

_____ _____ _____
Parent/Guardian Signature | Home Phone Number | Date Signed

Section B: To be completed by child's Physician / recognized Medical Authority (if describing a disability).

Does the child have a disability? ☐ Yes ☐ No
If yes, describe the major life activity affected by the disability _____
_____

Does the child have a non-disabling medical condition? ☐ Yes ☐ No
If yes, describe the medical condition _____
_____

Does the child have special nutritional or feeding needs? ☐ Yes ☐ No
If yes, describe the specific need _____
_____

If you answered YES to any of the questions above, complete Section C and return to the nurse/health clerk at the child's school.

Section C: **PHYSICIAN REQUEST** Diet Prescription:
(To be completed by the child's Physician or a recognized Medical Authority).

Note: For any food item to be omitted from diet, a substitute **must** be listed.

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____

Please attach additional instructions if necessary.

I certify that the student noted above needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____ _____
Health Care Provider Signature | Date Signed

Name: _____ Office Phone: _____ Fax:_____
Type or Print