Dear Parents and Guardians,

We want to introduce ourselves and create the beginnings of a partnership in your student's health. We are best able to care for your child if we have the information that we need to respond quickly and efficiently. Please contact us with any information that may be important in caring for them.

Please find attached our required forms for asthma, anaphylaxis, and medication administration. We wanted to review our basic protocols and ask for your help. If medication is potentially needed during the school day, please send it to school in a Ziplock bag labeled with their name. The medication should clearly show their name, medication name, and dosage instructions on the pharmacy label. Please let the nursing staff or division administrator know to expect that medication to be delivered that day. These medications should correlate with the medication administration form that is on file.

In the Preschool and Lower School, inhalers and epi-pens will be stored in a red backpack in the child's classroom. These bags go with your child throughout the day when they leave the classroom.

In Middle and Upper School, these medications can be stored in the division office (preferable) or in the child's bag. If the child is involved in after-school activities that take them to the athletic complex, these medications should be carried in a backpack that goes to each location. Most importantly, please communicate with the nursing staff as to where the medication is kept. Please check in with your child periodically to ensure that the medication is where it is expected to be.

Other medications that are emergency medications will be stored in either the appropriate division office or the nursing office.

Please advise us as to your intentions:

☐ Emergency Medication will be stored in the red backpack (Preschool and Lower School Only)

☐ Emergency Medication will be stored in the appropriate division office

☐ Emergency Medication will be stored in the child's backpack

☐ Other medication _____(med name) will be stored in the appropriate division office

☐ Other medication _____(med name) will be stored in the nursing office

We are available to answer any questions or discuss any concerns.

Kind regards,

Victoria Filiatreau, RN
Leslie Graves, APRN
Emily Mills, RN

Sayre Nursing Staff

nursing@sayreschool.org

859-244-2646 (office)

LIFE-THREATENING ALLERGY EMERGENCY ACTION PLAN

School Year: _____

(This form will be made available to teachers and appropriate school staff.)

Student's Name: _____ DOB: ___ / ___ / ___ ___ ___

Teacher: _____ Grade: _____

Parent/Guardian(s) Name(s): _____ _____

Address/Zip Code: _____

Doctor: _____ Phone #: _____ Hospital of Choice: _____

TYPICAL SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	Symptoms:
MOUTH	Itching and swelling of the lips, tongue, or mouth.
THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
SKIN	Hives, itchy rash, and/or swelling about the face or extremities.
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea.
LUNG	Shortness of breath, repetitive coughing, and/or wheezing.
HEART	"Thready" pulse, "passing-out"

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!

STUDENT'S ALLERGY IS TO: _____

STUDENT'S TYPICAL REACTION: _____

STUDENT'S OTHER KNOWN ALLERGIES: _____

ACTION TO BE TAKEN:

1. If ingestion/exposure is suspected, give: _____
   Medication/Dose/Route

   Medication/Dose/Route
2. Location of Medication/Epi-Pen: _____
3. Call Rescue Squad (911) if Epi-Pen is used.
4. Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

   Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Or call Emergency Contact from list below if unable to reach Parent/Guardian.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENT/GUARDIAN(S) CANNOT BE REACHED!

EMERGENCY CONTACTS

1. _____
   Relation: **Phone:**
2. _____
   Relation: **Phone:**
3. _____
   Relation: **Phone:**

REVIEWED BY: _____ *RN* *DATE:* _____

ALLERGY QUESTIONNAIRE

School Year: _____

Student's Name: _____ **DOB:**___ / ___ / ___

1. Allergies: _____ _____

2. Date of student's last allergic episode? ___ / ___ / ___ ☐ Never had an allergic episode ☐ Epi Administered
   What happened? _____ _____

3. Diagnosed by skin/blood testing? **Yes** ☐**No** Date _ / _ / _ **Allergists Name:** _____ **Phone #** _____
4. Has student ever been hospitalized for an allergic episode? Yes ☐ No ☐ Date ____ / ____ / ____

5. Does your student react when they eat the above allergen? ☐Yes ☐No
   Type of reaction: ☐ Stomachache ☐ Itching ☐ Hives ☐ Itchy throat
   ☐Cough/Wheezing ☐ Anxiety/Restlessness ☐ Swollen lips or tongue
   ☐ Other_____

6. If this is a food allergy, do you plan to send lunch each day for your student? ☐Yes ☐No

7. Does your student react when they touch (**or are bitten/stung by, if Insect**) the above allergen? ☐Yes ☐No
   Type of reaction: ☐ Rash ☐ Itching ☐ Hives ☐ Itchy throat ☐ Cough/Wheezing
   ☐ Anxiety/Restlessness ☐ Swollen lips or tongue
   ☐ Other_____

8. Does your student react when they smell or inhale the above allergen? ☐Yes ☐No
   Type of reaction: ☐ Stomachache ☐ Itching ☐ Hives ☐ Itchy throat
   ☐Cough/Wheezing ☐ Anxiety/Restlessness ☐ Swollen lips or tongue
   ☐ Other_____

9. Can your student sit near someone eating the allergen? ☐Yes ☐No

10. Does your student know what the allergen looks like and how to avoid it? ☐Yes ☐No

11. What do you do at home (accommodations, diet restrictions, substitutions)? _____

12. Can your student eat food processed in a facility that also processes the allergen? ☐Yes ☐ No

13. Can the school send a letter home notifying the classroom about your student's allergy in order to decrease the chances the allergen will be brought to school by a classmate? ☐Yes ☐No

14. List the Medication(s) your student takes for allergic reactions (please fill out the attached Medication Authorization Form if needed) *

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____

15. Additional comments: _____

REVIEWED BY: _____ _____ *RN* *DATE:* _____

ASTHMA OR ANAPHYLAXIS MEDICATION AUTHORIZATION

STUDENT'S NAME: _____ DOB: ____/____/____ SCHOOL YEAR: 20____ - 20 ____

An amendment regarding the self-administration of asthma or anaphylaxis medication became effective in the Commonwealth of Kentucky as of April 21, 2004. KRS 158.834, as amended, states:

(1) "The board of each local public school district and the governing body of each private and parochial school or school district shall permit the self-administration of medications by a student with asthma or by a student who is at risk of having anaphylaxis if the student's parent or guardian:

(a) Provides written authorization for self-administration to the school; and

(b) Provides a written statement from the student's health care practitioner that the student has asthma or is at risk of having anaphylaxis and has been instructed in self-administration of the student's prescribed medications to treat asthma or anaphylaxis. The statement shall also contain the following information:

1. The name and purpose of the medications;
2. The prescribed dosage;
3. The time or times the medications are to be regularly administered and under what additional special circumstances the medications are to be administered; and
4. The length of time for which the medications are prescribed.

(2) The statements required in subsection (1) of this section shall be kept on file in the office of the school nurse or school administrator.

(3) The school district or the governing body of each private and parochial school or school district shall inform the parent or guardian of the student that the school and its employees and agents shall incur no liability as a result of any injury sustained by the student from the self-administration of his or her medications to treat asthma or anaphylaxis. The parent or guardian of the student shall sign a statement acknowledging that the school shall incur no liability and the parent or guardian shall indemnify and hold harmless the school and its employees against any claims relating to the self-administration of medications used to treat asthma or anaphylaxis. Nothing in this subsection shall be construed to relieve liability of the school or its employees for negligence.

(4) The permission for self-administration of medications shall be effective for the school year in which it is granted and shall be renewed each following school year upon fulfilling the requirements of subsections (1) to (3) of this section."

PHYSICIAN'S ORDER

I have examined this student for (diagnosis): _____

Name of Medication:_____ Dosage & Route: _____

Circumstances under which medication may be self-administered: _____

Length of time for which medication is prescribed: _____

Physician's Signature: _____ Date: ____/____/____

Printed Name: _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION

In recognition of, and compliance with, the above-quoted statute KRS 158.834, I:

1. Give this written authorization to Sayre School for self-administration of medications per paragraph (1) above.
2. Have **included written documentation from said student's health care practitioner** that complies with the terms and requirements of paragraph (1)(b) above **and includes all of the information required by sub-parts 1 through 4** of sub-paragraph (1)(b).
3. Acknowledge by this authorization/signed statement, in accordance with paragraph (3) above, that I have been informed that Sayre School and its employees and agents shall incur no liability as a result of any injury sustained by my child/student from the self-administration of his or her medications to treat asthma or anaphylaxis and I will indemnify and hold harmless Sayre School and its employees against any claims relating to the self-administration of medications used to treat asthma or anaphylaxis, provided that this shall not be construed to relieve liability of said school or its employees for negligence.

Parent/Guardian Signature: _____ Date: _____

Please print and sign this form, including written documentation from student's health care practitioner. Both must be on file in the Divisional Office.