Allergy History

Student Name: _____ Date of Birth: _____
ID #_____ Grade_____ School _____
Parent/Guardian Name(s) _____
Home Telephone _____ Cell _____ Work _____
Alternative Home Telephone _____ Cell _____ Work _____
Emergency Contact Name_____ Relationship to Student_____
Telephone Home_____ Cell_____ Work _____
Health Care Provider Telephone _____

1. Allergy to _____
2. Is your student's food allergy considered life threatening? ☐ No ☐ Yes
3. Does student have asthma? ☐ No ☐ Yes
4. Does student have any other health conditions or medication allergies we should be aware of?
   ☐ No ☐ Yes If yes, explain _____
5. Describe student's symptoms of allergic reaction _____
   _____
   _____
6. Is student able to identify foods that may cause a reaction? ☐ No ☐ Yes
7. Is student able to recognize symptoms of their allergic reaction? ☐ No ☐ Yes
8. Has student ever received medical care because of an allergic reaction to food?
   ☐No ☐Yes Health Care Provider Name_____
   Approximate Date_____
9. Are there and limitations, restrictions, precautions needed at school? ☐ No ☐ Yes

If yes, explain _____
_____

10. How do you usually treat food allergies at home?
    _____
    _____
11. Does student require allergy medication at school? ☐ No ☐ Yes, explain below

Medication Name	Amount	When to Use

12. This is the district's food allergy emergency action plan. If you want the District to follow a different plan, please have your healthcare provider write specific orders.

Call 911 for help if:

-EpiPen is used
-Parent/Guardian/Student request 911
-Symptoms of allergic reaction develop
-Doctor's orders states 911 to be called

_____ _____
Signature of Parent/Guardian Date

SBCUSD MIS#_____

Allergy Action Plan

Place Student Photo Here

Student Name:_____ Birth Date: _____
School:_____ Grade:_____ Teacher:_____

ALLERGIC TO THESE ALLERGENS: _____

☐ **Has Asthma** (increases risk for severe reaction)

☐ **Severe Allergy previously/suspected—Immediately give epinephrine & call 911– Start with Steps 2 & 3**

☐ **Mild Allergy –** Itching, rash, hives – **Give antihistamine, call school nurse and parent. Start with Step 1**

► STEP 1: IDENTIFICATION OF SYMPTOMS* ◄

*** Send for immediate adult assistance**

Symptoms:		**Type of Medication to Give:** (Determined by physician authorizing treatment)	
➢	If exposed to allergen, or allergen ingested, but ***no symptoms***	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Mouth –** Itching, tingling, or swelling of lips, tongue, mouth	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Skin –** Hives, itchy rash, swelling of the face or extremities	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Gut –** Nausea, abdominal cramps, vomiting, diarrhea	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Throat –** Tightening of throat, hoarseness, hacking cough	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Lung** –** Shortness of breath, repetitive coughing, wheezing	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Heart** –** Faint, pale, blueness around mouth or nail beds, weak pulse, low B/P. .	☐ **Epinephrine**	☐ **Antihistamine**
➢	**Other** –** _____	☐ **Epinephrine**	☐ **Antihistamine**
➢	If reaction is progressing (several of the above areas affected) give	☐ **Epinephrine**	☐ **Antihistamine**

**** Potentially life-threatening. –** Note: The severity of symptoms can quickly change.

► STEP 2: GIVE MEDICATIONS ◄

(Twinject™ NOT Recommended for School Use)

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® ☐ EpiPen Jr® ☐ Twinject™ 0.3 mg ☐ Twinject™ 0.15 mg

- **If Epinephrine is given, paramedics must be called! PROCEED TO STEP 3 BELOW.**

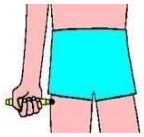
Antihistamine/other: give _____ *(Medication name & amount)* **by** _____ *(route/method)*

- **Notify** parents and school nurse • **Observe** for increasing severity of symptoms • **Call 911** asneeded

IMPORTANT: Do NOT depend on asthma inhalers and/or antihistamines to replace epinephrine in a severe reaction.

EpiPen Directions:

a. Pull off the GRAY Safety Cap
b. Place BLACK TIP near OUTER-UPPER THIGH
c. Swing and jab firmly until hearing or feeling a click
d. Hold EpiPen in place **10 SECONDS**, remove, massage area
e. Dispose of in red sharps container or give to paramedics



- The EpiPen can be injected through clothing.
- The individual may feel his/her heart pounding.
  - This is a normal reaction to the medication.

► STEP 3: EMERGENCY CALLS ◄

1. **CALL 911** – *Seek emergency care*. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call School Nurse
3. Call Parents or Emergency Contacts

Parent completes Parent and Emergency Contact Names and Information below:

Parents/Emergency Contact *Names*:	*Relationship:*	*Phone Number(s):*
a. _____ 1.)	_____ 2.)	(____) _____ (____) _____
b. _____ 1.)	_____ 2.)	(____) _____ (____) _____

Parent/Guardian Signature _____ Date _____
(Required)

Physician completes form through Step 2

Physician Name (Printed) _____ Phone Number: (____) _____

Physician Signature _____ Date: _____
(Required)

7/2020

School Phone # _____
School Fax # _____

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

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

PHYSICIAN USE ONLY

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ ***Date:*** _____

Physician Name: _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Parent Request
For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.

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

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

B. For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: _____ ***Date:*** _____

Parent Signature: _____ ***Date:*** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

*California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of site where meal will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **Age of Child or /Participant:** Print the age of the child or participant. For infants, please use date of birth.

6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

7. **Phone Number:** Print the phone number of parent or guardian.

8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.

9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

10. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".

11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

14. **Printed Name:** Print name of state licensed healthcare professional.

15. **Phone Number:** Phone number of state licensed healthcare professional.

16. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genitourinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307
(760) 552-6700 • (760) 242-5363 FAX

Authorization for Use and/or Disclosure of Information

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

School Site: _____ LEA of Residence: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

AUTHORIZATION

I authorize the individual/agency named below to disclose the above-named student's medical and/or educational information to the receiving LEA as indicated under this Authorization.

DISCLOSING AGENCY

Individual/Agency DISCLOSING Information: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ E-mail Address: _____

RECEIVING AGENCY

Individual/Agency RECEIVING Information: Victor Valley Union High School District

Street Address: 16350 Mojave Drive City: Victorville State: Ca Zip Code: 92301

Contact Name: Julie Dieppa, RN Phone: 760-955-3201 Ext. 10427 E-mail Address: jdieppa@vvuhsd.org

☐ **I agree that the Individuals/Agencies above may mutually share information.**

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

_____ **REVOCATION:** I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this Authorization.

_____ **REDISCLOSURE:** I understand that educational health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the receipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

_____ **HEALTH INFORMATION:** I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to assure medical treatment.

SPECIFY RECORD(s):

☐ Medical/Medication ☐ Mental Health/Psychiatric ☐ Drug/Alcohol
☐ Educational Records ☐ STD/HIV Test Results ☐ Other: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ **(Date)**
or for one year from the date of signature if no date is entered.

I request that the information released pursuant to this Authorization be used for the following purposes:

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: _____ Date: _____

Student Signature: *(if applicable)* _____ Date: _____