

ALLERGY & ANAPHYLAXIS School Health Plan (SHP) Emergency Action Plan (EAP) Medication Authorization and Self-Administration Form In Accordance with UCA 26-41-104 Utah Department of Health/Utah State Board of Education		PHOTO	 NURSING & HEALTH SERVICES Phone: 435-752-3925 Fax: 435-792-7796	RN Approval Date:
Asthma: ☐ No ☐ Yes (If yes, high risk for severe reaction, please also complete Asthma Action Plan)				
STUDENT INFORMATION				
Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:	Email:		
Physician:	Phone:	Email:		
School Nurse:	Phone:	Email:		
ALLERGEN(S)				
Allergy to:				
☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms. ☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if NO symptoms are apparent. ☐ N/A – Follow in accordance with allergy action plan below.				
YELLOW: Mild to Moderate Reaction		ACTION		
<u>MILD SYMPTOMS</u> • Itchy/runny nose • Itchy mouth • A few hives, mild itching • Mild nausea/discomfort		For <u>MILD SYMPTOMS</u> from <u>A SINGLE SYSTEM</u> area, follow the directions below: • Antihistamine may be given, if ordered by a healthcare provider. • Stay with the person; alert emergency contacts. • Watch closely for changes. If symptoms worsen, give epinephrine. FOR MORE THAN ONE SYMPTOM, GIVE EPINEPHRINE!		
RED: SEVERE REACTION		ACTION		
<u>SEVERE SYMPTOMS</u> • Short of breath, wheezing, repetitive coughing • Skin color is pale, blue • Faint, dizzy, weak pulse • Tight, hoarse, trouble breathing or swallowing • Significant swelling of the tongue and or lips • Many hives over body, widespread redness • Repetitive vomiting, severe diarrhea • Feeling something bad is about to happen, anxiety, confusion		<u>1. INJECT EPINEPHRINE IMMEDIATELY!</u> - Call 911 (EMS). Tell them the student is having anaphylaxis and may need Epinephrine when they arrive. - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. - Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes. - Alert emergency contacts. - Give other medication (ONLY IF PRESCRIBED). DO NOT use other medication in place of Epinephrine. (Don't try to give the following): • Antihistamine • Inhaler (bronchodilator) if wheezing - Student must be transported to the emergency department even if symptoms resolve for observation and further treatment. Should remain for at least 4 hours because symptoms may return.		
MEDICATION		Epi-Pen Administered Before: ☐ Yes ☐ No		
Medication	Dose	Side Effects		
Epinephrine: ☐ Yes ☐ No	☐ 0.15 mg IM ☐ 0.3 mg IM			
Antihistamine:				
Other: (e.g., inhaler)				

PRESCRIBER TO COMPLETE			
The above-named student is under my care and has the diagnosis of Allergies. In order to keep this child in optimum health and to help maintain school performance, it is necessary that these orders are to be completed during school hours. This order expires at the end of the current school year or on an earlier date set by the provider: _____. ☐ It is medically appropriate for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times. ☐ Student can self-carry and self-administer EAI if needed, when able and appropriate. ☐ Student can self-carry, but NOT self-administer EAI. ☐ It is NOT medically appropriate to carry and self-administer this EAI medication. Please have the appropriate designated school personnel maintain this student's medication for use in an emergency. ☐ Additional Orders:			
Prescriber Name:		Phone:	
Prescriber Signature:		Date:	
PARENT TO COMPLETE (Parent must sign in both places)			
PARENT RESPONSIBILITIES			
1. The parent/guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name. 2. The parent/guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given. 3. If a student has a change in his/her prescription the parent/guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent/guardian will complete an updated Epinephrine Auto Injector Medication Authorization and Self-Administration Form (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.			
PARENT/GUARDIAN AUTHORIZATION (Parent must sign in both places)			
Checked boxes must match Health Care Provider Orders above			
☐ I authorize my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an Epinephrine Auto Injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.		☐ I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate. ☐ I authorize my student to self-carry, but NOT self-administer EAI.	
☐ I DO NOT authorize my child to carry and self-administer this medication. Please have the appropriate designated school personnel to maintain my child's medication for use in an emergency.			
Parent Signature:		Date:	
I authorize my child to receive specified procedures at school as directed by the healthcare provider and/or agreed upon with the District RN. As the parent/guardian of the above-named student, I authorize District RN(s) and trained, designated unlicensed staff to perform tasks outlined in the Health Plan/Emergency Action Plan. I release, indemnify, and hold harmless the District RN(s) and designated staff from any claims related to health interventions, provided they follow the healthcare provider's written instructions and/or agreed upon within this plan of care. I consent to communication and information sharing between the prescribing provider and District RN(s) as needed for managing my student's condition and administering medication. I understand that the information in this plan will be shared with school staff and EMS as necessary. EMS will be called in emergencies. I will notify District RN(s) of any changes in my child's health status, care, or medication. Parents/guardians and the student are responsible for providing all required supplies, medications, and equipment. I understand that this document is not valid, and no accommodations will be made, until it is signed by all required parties.			
Parent Signature:		Date:	
Emergency Contact Name:		Relationship:	
		Phone:	
SCHOOL NURSE (or school office staff, health aide)			
☐ Signed by PCP and parent ☐ Medication is appropriately labeled ☐ Medication Log Generated			
This health care plan is to be distributed via PowerSchool or as needed by the front office to all "need to know" staff.			
School Nurse Signature:		Date:	

Medical Statement to Request Special Meals, Accommodations, Milk Substitutions

1. Site Name (School/Sponsor):	2. Name of Parent/Guardian	3. Email Address	
4. Name of Child*	5. Date of Birth	6. Telephone Number	
7. State the medical condition requiring accommodation.			
<i>This section <u>must be completed by a licensed medical authority</u>. Refer to the reverse side of this page for definitions.</i>			
8. Provide a brief description of the major life activities or bodily functions affected by the condition. *			
Consuming foods to be omitted may result in: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Itching ☐ Swelling ☐ Rash ☐ Wheezing/Coughing ☐ Other:			
9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted.*			
Foods and/or beverages to be excluded: *		Foods and/or beverages to be substituted: *	
10. Modified texture (if applicable): ☐ Chopped ☐ Ground ☐ Puree			
11. Adaptive Equipment Needed (if applicable):			
12. Signature of Medical Authority & Credentials*	13. Printed Name*	14. Telephone Number	15. Date*
I give permission for the institution's personnel responsible for implementing my child's prescribed diet order to discuss my child's Special dietary accommodations with any appropriate institution staff and to follow the prescribed diet order for my child's meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by institutions personnel. Signature of parent or guardian: _____ Date: _____			

***Required**

A licensed medical authority is defined as an individual who has the authority to write a medical prescription. In Utah, this includes:

- Medical Doctor
- Physician's Assistant (PA)
- Osteopathic Physicians (DO)
- Advance Practice Registered Nurses (APRN)
- Naturopathic Physicians (ND or NMD)
- For programs operating in the Bureau of Indian Education schools, the Indian Health Service requires that prescribing practitioners have Drug Enforcement Administration licenses.

USDA Guidelines for Accommodating Special Dietary Needs

Institutions and agencies participating in federal nutrition programs **must** comply with requests for special dietary meals and any adaptive equipment with a documented disability and completed request form.

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) **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.

Major Life Activities- functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Major Bodily Functions- functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions

Physical or Mental Impairment- (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, including speech organs; cardiovascular; reproductive, digestive, genitor-urinary; 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.

Record of Impairment- having a history of or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities. Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability, are still considered to have a disability and require an accommodation.