SCS
SCOTT COUNTY SCHOOLS

Dear Parent/Guardian:

According to our health records, your child has an allergy that may require having an epinephrine auto-injector on hand for possible severe allergic reactions.

Enclosed are the forms that need to be completed by the Parent/Guardian and/or Physician and returned to the School Nurse. We must have the medication form along with the auto-injector so that staff may administer it in case of an emergency. Even if your child self-carries his auto-injector, we must have the proper paperwork so that staff can assist him in the administration in an emergency. Please be sure the physician indicates on the medication form if this medication can be self-carried.

The information on these forms will help us determine how best to help your child during the school day and will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your child, please let us know of any changes in your child's medical condition or emergency daytime phone numbers.

The following forms need to be completed and returned to your child's school at the start of the school year.

- Administration of Medication Form (parent and physician)
- Allergy and Anaphylaxis Emergency Plan (parent and physician)
- Allergy Individualized Health Plan (parent)

Please contact the School Nurse if you have any questions.

We are looking forward to a great year with your student!

Scott County School District Nurse

Billy Parker, Superintendent
2168 Frankfort Road | Georgetown, Kentucky 40324 | 502-863-3663 | www.scott.kyschools.us
Equal Opportunity Employer

SCS
SCOTT COUNTY SCHOOLS

Management of Students with Allergies Guidelines

SCHOOL SITE RESPONSIBILITIES

1. Identify children requiring special dietary modifications.
2. The Principal or designee shall refer a student with known or suspected special dietary needs for special services as required by law and shall notify the Special Education Director, Section 504 Coordinator, school nurse or health services assistant, as appropriate, given the nature of the medical requirement or disabling condition known or suspected.
3. The Principal or designee shall make staff and the student aware of precautions needed related to field trips, classroom parties, allergy alert identification, intervention strategies, and other issues necessary to promote student safety.
4. Admissions and Release Committee (ARC) chairs, Section 504 chairs, the school nurse, or the school nurse assistant, as appropriate, shall communicate plan requirements to all potential plan implementers, such as designated School Nutrition staff, the student's teachers, etc.
5. Monitor and update the IEP, Section 504 plan, or health plan as needed.
6. Provide information to educate parents and students regarding food allergies.
7. Assure that appropriate staff is trained annually in the administration of Epi-Pens.
8. Include students with allergies in school activities; student should not be excluded from school activities solely based on their allergy

CLASSROOM TEACHERS RESPONSIBILITIES

1. Discuss field trips with the family and students with allergies to decide appropriate strategies for managing the allergy
2. Be sure volunteers, student teachers, aides, specialists and substitute teachers are informed of the student's allergies and necessary safeguards
3. Leave student information in an organized, prominent, and accessible format for substitute teachers.
4. Inform parents of any school events where food will be served if a student has a food allergy.
5. Educate classmates and parents regarding food allergies.
6. Participate in mandatory in-service training that addresses the student with allergies.
7. Hang signs on classroom doors to alert others of a food allergy
8. Educate classmates to avoid endangering, isolating, stigmatizing, or harassing student with allergies, be aware how the student with allergies is being treated, and enforce school rules about bullying and threats.

FOOD & NUTRITION SERVICES RESPONSIBILITIES

1. Provide food item services and/or substitutions for students based on medical need. Menus will not be modified based on personal preference.
2. Provide training to school nutrition personnel on how to react to food allergies and food-related emergencies and how to modify menus.
3. Maintain special dietary information on each student identified as having special dietary needs and update this information as needed.
4. Create and maintain a peanut free table in the cafeteria.
5. Provide a soy butter alternative for all peanut butter items on the school menu.

PARENT/GUARDIAN RESPONSIBILTIES

1. Notify the school of allergy or special dietary need related to a disabling condition or medical necessity.
2. Fill out and return Medication Administration Form, Emergency Plan Form, and Individualized Health Plan.
3. Provide medical information from a District-approved recognized medical authority (RMA) authorized to practice within the State of Kentucky as noted in the student's IEP, 504 plan, or health plan.
4. Provide updated medical information as requested by the District.
5. Participate in any meetings or discussions regarding the student's allergy plan.
6. Notify the school of any changes relating to the allergy or special dietary need.
7. Educate the student in the self-management of their allergy including:
    a. Strategies for avoiding exposure to allergen
    b. Symptoms of allergic reactions
    c. How and when to tell an adult they may be having an allergy-related problem
    d. How to read food labels when applicable (age appropriate)
8. Provide the School Nurse with a Physician's Statement if student no longer has allergies
9. If your child has a food allergy, leave a bag of "Safe Snacks" in your student's classroom so there is always something your student can choose from during an unplanned event

STUDENT RESPONSIBILITIES

1. Follow his/her IEP, Section 504 plan, or health plan.
2. Students with food allergies should not trade food with others.
3. Should notify an adult immediately if they eat something they believe may contain the food to which they are allergic or are bitten or stung by an insect to which they are allergic.
4. Learn to recognize symptoms of an allergic reaction.
5. Learn to read labels when appropriate.

SCS
SCOTT COUNTY SCHOOLS

ALLERGY INDIVIDUAL HEALTH PLAN (IHP)

(picture here)

School Year_____

ALLERGENS: _____

Student Name: _____ DOB: ____/____/____

Teacher: _____ Grade: _____

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

Address: _____

Allergist/Doctor: _____ Phone: _____

Parent/Guardian 1 Contact Number: _____

Parent/Guardian 2 Contact Number: _____

Emergency Contact if unable to reach Parent/Guardian:

Name: _____ Phone:_____ Relation: _____

1. Date of students last allergic episode: ____/____/____
   What happened? _____
2. Diagnosed by skin/blood testing? YES or NO Date: _____
3. Has student ever been hospitalized for an allergic episode? YES or No Date: _____
4. Does your child react when they **eat** the above allergen? YES or NO
   Type of reaction: Stomachache Itching Itchy throat
   Cough/Wheezing Anxiety/Restlessness Swollen lips or tongue
   Other_____
5. If this is a food allergy, will you be sending lunch? YES or NO

6. Does your child react when they **touch** (or are bitten/stung if insect allergy) the above allergen? YES or NO

   Type of reaction: Rash Itching Itchy Throat
   Cough/Wheezing Anxiety/Restlessness Swollen lips or tongue
   Hives Other_____

7. Does your child react when they **smell or inhale** the above allergen? YES or NO

   Type of reaction: Stomachache Itching Itchy Throat
   Cough/Wheezing Anxiety/Restlessness Swollen lips or tongue
   Other_____

8. Can your child be near someone eating the allergen? YES or NO

9. Does your child know what the allergen looks like and how to avoid it?
   YES or NO

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

    _____

    _____

11. Can your child eat things processes in a facility that also processes the allergen? YES or NO

12. Can the school send a letter home notifying the classroom about your child's allergy in order to decrease the chances the allergen will be brought to school by classmate?
    YES or NO

13. Additional comments:

    _____

    _____

    _____

NOTE: If your child requires an EpiPen, you and your healthcare provider must complete a Medication Form and an Emergency Action Plan. These forms must be brought to the school at the beginning of each school year.

Reviewed by: _____RN Date: ____/____/_____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Attach child's photo

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses
Epinephrine, intramuscular (list type):_____ Dose: ☐ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

© 2017 American Academy of Pediatrics. All rights reserved. Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: (___) _____-_____

Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

© 2017 American Academy of Pediatrics. All rights reserved.

Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:** _____

Student's Age: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER "OTC") MEDICATION

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Restrictions and/or important side effects: ☐ No restrictions/side effects ☐ Yes. Please describe:

_____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Pursuant to KRS 158.832 to 158.836, Scott County Schools permits a student to possess and self-administer medications for asthma, diabetes, or anaphylaxis at school and at school-related function upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

Student has been instructed in self-administering the medication to be completed for asthmatic, diabetic, or severe allergic reactions (anaphylaxis) ONLY: ☐No ☐Supervision Required ☐ Supervision Not Required

Student must carry this medication on his/her person: ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

_____ _____

Physician/Health Care Provider Signature ***Date***

_____ _____

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ **Fax #:** _____

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

SCHOOL PERSONNEL: PLEASE ENSURE PAGE 2 OF THIS FORM IS ALSO COMPLETED.

Permission Form for Prescribed or Over-the-Counter Medication

FOR ALL MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee _____ Date _____