

Colonial School District

Release Form

Student Possession and Use of Auto-Injectable Epinephrine

(in accordance with 14 DE Admin. Code 612 and 817)

I am the parent/legal guardian of _____ ("Student").

Attached is a copy of the so named Student's prescription to possess and use an auto injectable epinephrine.

I authorize the so named Student to possess and use the auto-injectable in school and on field trips without supervision of the school nurse, or any other employee.

The school nurse shall make the assessment based upon the maturity and responsibility level of the said Student to carry the medication and administer as prescribed.

I release the District, the Board of Education, and District employees from any and all liability arising out of the Student's possession and use of the auto-injectable epinephrine in school, or during any school activity.

Parent/Legal Guardian

Date

Student

Date

School Nurse

Date

Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

STUDENT NAME:

DATE OF BIRTH:

SCHOOL:

GRADE:

PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- | | |
|--|---|
| ☐ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea | ☐ Respiratory: shortness of breath, repetitive coughing, wheezing |
| ☐ General: panic, sudden fatigue, chills, fear of impending doom | ☐ Skin: hives, itchy rash, swelling about face or extremities |
| ☐ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth | ☐ Throat: feeling tightness in the throat, hoarseness, hacking cough |
| | ☐ Other: _____ |

Treatment

1. Administer epinephrine (dosage/route/interval) _____
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: _____

Student may carry & self-administer epinephrine
☐ YES ☐ NO

Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

Foods to omit:

Substitutions:

Foods to omit:

Substitutions:

- | | |
|---|-------|
| ☐ Eggs | |
| ☐ Whole | _____ |
| ☐ Ingredient in Recipe | _____ |
| ☐ Other | _____ |
| ☐ Wheat | _____ |
| ☐ Gluten | _____ |
| ☐ Trace Amount | _____ |
| ☐ Ingredient in Recipe | _____ |
| ☐ Soy | _____ |
| ☐ Soy Lecithin | _____ |
| ☐ Oil | _____ |
| ☐ Isolated Soy Protein | _____ |
| ☐ Ingredient in Recipe | _____ |
| ☐ Other | _____ |

- | | |
|---|-------|
| ☐ Milk | |
| ☐ Milk | _____ |
| ☐ Cheese | _____ |
| ☐ Whey | _____ |
| ☐ Ingredient in Recipe | _____ |
| ☐ Other | _____ |
| ☐ Nuts | _____ |
| ☐ Tree Nut | _____ |
| ☐ Peanut | _____ |
| ☐ Other | _____ |
| ☐ Fish | _____ |
| ☐ Shellfish | _____ |
| ☐ Other Not Included on List | _____ |

Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: _____
Asthma: (circle) YES NO _____

Response for reaction to all other allergens: Give prompt treatment if the student has any of the following symptoms:

Treatment

1. Administer: _____
2. Contact: _____
3. Other: _____

Healthcare Provider Name (printed): _____ MD DO APPA

Date: _____

Healthcare Provider Name (signature): _____

Phone: _____

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

Parent Signature: _____ Date: _____ Phone #: _____ 8/2013, Rev. 1/2