



Life-Threatening Conditions

Dear Parent and/or Guardian,

According to our records, your student has a life-threatening health condition. Washington State Law requires children with life-threatening conditions to have a medication or treatment order and health care plan on file prior to attending school. This law, called Substitute House Bill 2834, took effect on June 13, 2002. The medication or treatment order must address the life-threatening condition and it must be on file with the school prior to the child attending school.

Under the law, "life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition, our school nurses will be responsible for putting a nursing care plan in place. The law provides that a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to be provided at school.

At the start of every school year you will need new medication order forms and plan of care filled out by your healthcare provider as well as unexpired medication in the original container, and an updated care plan that has been prepared by the school RN and signed by the parent/Guardian prior to the student's first day of school.

For your convenience forms have been included related to your student's health condition. You may also use the link included to access them on the Bethel School District website. Please ensure that your healthcare provider completes all forms and that their contact information is printed for any clarification needed. Note that there are permission portions of forms as well. Return this form to your child's school nurse as soon as possible.

Upon receipt of the information from your healthcare provider, the school nurse will contact you to develop an appropriate nursing plan. She will then need to train the staff. Your child may not be able to start school on the first day of school if the orders are not at school three business days prior to school starting.

Sincerely,

Bethel School District Health Services

bethelsd.org/resources/health-room-forms

3/25/2025 ARRN

Dear Health Care Provider,

The state of Washington has published *guidelines for care of students with life-threatening allergies. The guidelines are comprehensive; however, the message to alert health care providers who prescribe emergency medications to be given at school to students who had a contact with an allergen is:

For students with a medical order to administer epinephrine at school to treat anaphylaxis or possible anaphylaxis, the recommended protocol after exposure is to immediately:

- 1. Administer Epinephrine**
- 2. Call 911**
- 3. Call Parents**

Benadryl can no longer be administered first and there cannot be a “wait and watch” period of time. This change is necessary because:

1. Most schools do not have full time nurses in the building. Even if the nurse is in the district, it is impossible for the nurse to be on location at all times to provide an *accurate assessment of the student’s health status*.
2. Unlicensed school staff (health clerks, secretaries, principals, teachers, coaches, bus drivers, etc.) will be the front line adults on site when the student has a contact to the specific allergen causing potential anaphylaxis.
3. **Unlicensed school staff members are unprepared to assess the student’s health status to determine whether or not to administer epinephrine and/or when to administer it. *Registered nurses may not delegate assessment and clinical judgment to unlicensed school staff.***
4. For the safety of the student, epinephrine will be administered immediately as ordered by the health care provider.

Thank you for your assistance in implementing this requirement.

If you have any questions, please contact the school nurse.

**Guidelines for Care of Students with Anaphylaxis* available at <http://www.k12.wa.us/HealthServices/Publications/09-0009.aspx>

Bee or Insect Allergy Form

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating bee allergy: _____ Phone _____

Do **you think** your student's bee allergy may be **life-threatening**? No Yes

(If YES, please see the school nurse as soon as possible.)

Does your student's **health care provider think** the bee allergy may be **life-threatening**? No Yes

(If YES, please see the school nurse as soon as possible.)

History and Current Status

What type of stinging bee or insect has your student reacted to? _____

How many times has your student had a reaction? Never Once More than once, please describe: _____

When was the last reaction? _____

Are the reactions: staying the same getting worse getting better

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction? No Yes, please describe: _____

Has your student ever received or used an EpiPen® or other injection as treatment? No Yes, please describe: _____

Triggers and Symptoms

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things your child might say.)* _____

How quickly do the signs and symptoms appear after the sting? ___ seconds ___ minutes ___ hours ___ days

Treatment

Does your student understand how to avoid getting a bee sting or insect bite? Yes No

What do you do at home if there is a reaction to a bee sting or insect bite? _____

What treatment or medication has your health care provider recommended for an allergic reaction? _____ None

Have you used the treatment or medication? No Yes

Does your student know how to use the treatment or medication? No Yes

Please describe any side effects or problems your student had in using the suggested treatment or medication. _____

If medication is to be available at school, have you filled out a medication form for school?

Yes

No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication or treatment supplies to school?

Yes

No, I need to get the medication/treatment and bring it to school.

What do you want the school to do in case of a bee sting or insect bite? _____

Parent/Guardian Signature: _____ Date: _____



Student Name	DOB	School	Fax	School Year

The above student may require treatment to prevent/treat anaphylaxis while at school.

Student has anaphylactic response to the following allergens: _____

The symptoms of anaphylaxis may include breathing difficulty, facial/throat swelling or tingling, hives, rash itching, stomach cramps, nausea/vomiting, dizziness, swelling away from the site of a bee sting and _____

The treatment plan for preventing/treating anaphylaxis at school is as follows: *(check all that apply)*

If student has a suspected ingestion exposure to allergen and/or exhibits any symptoms of anaphylaxis, Give epinephrine IMMEDIATELY

Epinephrine auto-injector 0.3mg IM

Epinephrine auto-injector 0.15mg IM

Epinephrine Intranasal _____ mg

Repeat dose of epinephrine to be given if _____

CALL 911 at the time epinephrine is given and notify parent/guardian.

This student also has asthma and may be at higher risk for developing anaphylaxis.

- o See separate orders for asthma medication(s)

Student and parent/guardian have been instructed in use of epinephrine as ordered	Yes	No
Student may carry the epinephrine as ordered	Yes	No
Student may self-administer the epinephrine as ordered	Yes	No

Health Care Provider's Signature _____ Phone _____ Fax _____

Health Care Provider's Printed Name or Stamp _____ Date _____

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY

Parent/Guardian's Permission:

I request that the school nurse, principal, or designated staff member be permitted to discuss my child's medical issues with health care providers and to administer to my child (*name of child*) _____ or allow my child to carry and self-administer as indicated above, the medication prescribed by (*name of provider*) _____ for the _____ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by the school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or legal guardian of the child named.

Parent/Guardian Signature: _____ Date: _____

Parent Contacts: Home: _____ Cell: _____ Work: _____ Other: _____

STUDENT DEMONSTRATES SKILL NECESSARY TO SELF-ADMINISTER MEDICATION AS ORDERED ABOVE

School Nurse Signature: _____ Date: _____



Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

Student	Student Name: _____ Birth Date: _____ _____												
Released By	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student												
Released To	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student												
Purpose	For the purpose(s) of: <input type="checkbox"/> This information may be used or disclosed in connection with mental health treatment/services and healthcare operations. <input type="checkbox"/> Other purposes (specify each purpose): _____ _____												
Information to be Disclosed	Description or nature of information to be used and/or disclosed: (check all that apply) <input type="checkbox"/> Assessment/Intake Summary <input type="checkbox"/> Psychiatric Reports <input type="checkbox"/> Service/Treatment Plan <input type="checkbox"/> Progress Report <input type="checkbox"/> Safety/Crisis Plan <input type="checkbox"/> Other records(specify): _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;"> Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released. </td> </tr> <tr> <td style="padding: 5px;"> Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released. </td> </tr> </table>	Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.	Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.								
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Notices	I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.												
Expiration	I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period: Date: _____												
Signatures	I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Signature of student</td> <td style="width: 60%; border-bottom: 1px solid black; text-align: center;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Signature of legal/personal representative</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship to student</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%;">Update of Authorization</td> <td style="width: 40%;">Signature 1: _____</td> <td style="width: 35%;">Date: _____</td> </tr> <tr> <td></td> <td>Signature 2: _____</td> <td>Date: _____</td> </tr> </table>	Signature of student	Date	Signature of legal/personal representative	Relationship to student	Date	Date	Update of Authorization	Signature 1: _____	Date: _____		Signature 2: _____	Date: _____
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