INDIVIDUAL HEALTH PLAN / EMERGENCY CARE PLAN FOR STUDENT WITH SEVERE ALLERGY

TO BE RENEWED EACH SCHOOL YEAR

Student Name ____ Birth Date: _______________
School____________________ Grade _______ Teacher________________ SchoolYear_______________

My student still has this allergy:

YES Complete form, sign & date, and return to your student's school.
NO Skip to the end of this form, sign & date and return to your student's school.

My student is allergic to:____

Reaction occurs from: ingestion contact inhalation i insect sting

My student has had a life threatening, anaphylactic reaction to this allergen: YES NO

Does your student also have asthma? YES (*Higher risk for severe allergic reaction*) NO

SIGNS OF AN ALLERGIC REACTION INCLUDE:

(Please check symptoms most common to your student)

Trouble breathing
Hives or swelling
Tightness of the throat
Hoarse voice
Nausea/vomiting
Abdominal pain
Diarrhea/crampy pain
Dizziness/fainting
Feeling of doom/confusion

Other_______________

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

History of reaction (date of last reaction / signs & symptoms of reaction):

____

Does your student recognize these signs and symptoms? YES NO
Will your student require a rescue medication to be given at school? YES NO

(If yes, a medication consent form must be on file with the school health office.)

Medication will be: In health office With Student (secondary only). Epinephrine expiration date:______

Health Care Provider Name: ______________________ Clinic__________________ Phone___________

Emergency Contacts (*list in order of who to call first*)

Name: _______________________ Relationship:____________ Phone:_____________ Phone:___________
Name: _______________________ Relationship:____________ Phone:_____________ Phone:___________

FOOD ALLERGIES

My student can identify all foods that should be avoided and can self-manage their food intake at school:

YES NO (explain): ____

It is the responsibility of the parent/guardian to review lunch menus and coordinate with the health office, dietary, and classroom teacher on how to manage mealtime, classroom snacks, and art projects.

The School cannot guarantee that the facility or dining area will be allergen free

SCHOOL ACTION/EMERGENCY PLAN (if exposure to allergen occurs):

If student has an epinephrine auto-injector for a bee sting allergy, it will be immediately given if stung

- Give prescribed medication if available. If symptoms do not improve, or symptoms return, additional dose of epinephrine can be given if ordered by a licensed prescriber and authorized by parent/guardian. (*The Consent Form for Administration of Emergency Allergy Medication During the School Day must be completed and signed by the health care provider and parent/guardian.)*
- Call 911 tell emergency dispatcher the person may be having anaphylaxis.
- 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. Calm and reassure student.
- Contact parent/guardian.
- Emergency transportation to hospital is recommended for further monitoring.

PARENT/GUARDIAN AUTHORIZATION

Select one

No epinephrine auto-injector at school. Follow Emergency Action Plan.

Student needs help with allergy signs and symptoms; epinephrine auto-injector will be administered as ordered. The epinephrine auto-injector must be properly labeled for the student.

Student can self-manage allergy signs and symptoms, **no epinephrine auto-injector at school.**

- Student will go to the health office if allergic reaction occurs, and 911 and parent will be called.

Student can self-manage allergy signs and symptoms and may independently carry/use epinephrine auto injector at school.

- The health office staff will assess the student's knowledge and skills to safely possess and use the epinephrine auto-injector in a school setting. If non-compliance or a change in status occurs, the School Nurse will contact parent/guardian to discuss a new agreement.
- Students who self-manage their allergy will NOT be monitored by school personnel on a daily basis.
- My student will notify a school staff member if he/she administers epinephrine so 911 can be called.

PARENT/GUARDIAN AUTHORIZATION

- I authorize the School Nurse/designee to communicate with appropriate school personnel regarding his/her health plan.
- I authorize the School Nurse/designee to exchange information with my child's health care provider related to his/her health plan.
- I will contact the School Nurse/designee if a change in the current plan is indicated.
- I understand if my student rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my student's health plan.

Parent/Guardian Signature:____ Date:________________

School Nurse Signature: ____ Date: _______________

CONSENT FORM FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION DURING SCHOOL DAY

TO BE RENEWED EACH SCHOOL YEAR

Before medication can be administered by school personnel this form must be completed and on file with the school health office

Student Name ____ Birth Date ____________________

School ______________________ Grade ________ Teacher __________________ School Year __________

PHYSICIAN / LICENSED PRESCRIBER ORDER

Medication: Epinephrine auto-injector type: ___________________________ Dose: ☐0.15 mg IM ☐0.3 mg IM

Instructions for giving medication:____

Criteria for repeat dosing:____

Possible side effects: ____

Other/Additional Directions: ____

Emergency Allergy Medication should be administered for the following type(s) of symptoms:

Trouble breathing
Hives or swelling
Tightness of the throat

Hoarse voice
Nausea/vomiting
Abdominal pain

Diarrhea/crampy pain
Dizziness/fainting
Feeling of doom/confusion
Other_________________

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

This student has received instruction and permission to self carry and independently manage: ___ YES ___NO

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: __________________________________ DATE:___________

PRINT NAME:___________________________Clinic_______________ Phone #:__________ Fax #____________

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my student during regular school hours by designated personnel as delegated, trained, and supervised by the School Nurse and ordered by the physician/licensed prescriber.
2. I will provide this medication in the original, properly labeled pharmacy container.
3. I authorize the School Nurse/designee to exchange information with my student's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my student.
5. I release school personnel from any liability in relation to the administration of this medication at school.
6. I will contact the School Nurse/designee if a change in the current medication is indicated.
7. Field Trips - I give permission for the trained school personnel to administer the medication on a field trip.
8. I have read and understand the Medication Guidelines included with this form.

Parent/Guardian Signature:____ Date:___________________

SCHOOL NURSE SIGNATURE:_______________________________Date:___________________

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without it. Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, after school, and bedtime. **If a new medication is started, the first dose must be given at home, unless it is a rescue medication.**

1. Administration of prescription and non-prescription medication by school personnel must only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian and Licensed School Nurse, regardless of the student's age.

   a. Mixed dosages in a single container will not be accepted for administration at school.
   b. If a half tablet is required for a correct dosage, it is the parent/guardian's responsibility to provide pre-cut tablets for administration at school.
   c. Altered forms of medication will not be accepted or administered at school.
   d. Narcotics/medical cannabis will not be administered at school.
   e. Aspirin-containing products will not be administered at school.
   f. Only FDA approved treatments will be provided at school.

2. **All medication (prescription and non-prescription) must be brought to and from school by a parent/guardian in its original container.** The following information must be on the prescribed container label:
   a. Student's full name
   b. Name and dosage of medication
   c. Time and directions for administration at school
   d. Physician/licensed prescriber's name
   e. Date (must be current)

3. New consent forms with licensed health care provider and parent/guardian signatures must be received each school year.

4. A new medication consent form is required when the medication dosage or time of administration is changed.

5. When a long term daily medication is stopped, a written physician/licensed prescriber's order is requested.

6. Medication will be kept in a locked cabinet in the health office unless authorized by the Licensed School Nurse, and must not be carried by the student.

7. Students with severe allergies who need their epinephrine auto-injector during the school day will be allowed to self-manage, carry, and be responsible for the administration of their epinephrine auto-injector with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the School Nurse.

8. Students with asthma who need to use their inhaler during the school day will be allowed to self-manage, carry, and be responsible for the administration of their inhaler with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the School Nurse.

9. Secondary students may carry and use **non-prescription** medication with written consent of their physician/licensed prescriber, parent/guardian, signature of student agreement, and with the consent of the School Nurse. This applies to all secondary students, regardless of age. This medication cannot contain ephedrine, pseudoephedrine, aspirin or medical cannabis. Special arrangements must be made with the School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.