SUSSEX COUNTY PUBLIC SCHOOLS

Allergy Health Care Plan and Medication Administration Authorization

Student's Name: ________________________ DOB: ______________ School: ______________________

School Year: ____________________

ALLERGY TO: ____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction if asthmatic

♥ STEP 1: TREATMENT ♥

Symptoms of an Allergic Reaction:		**Give Checked Medication (to be determined by physician/licensed prescriber)	
• If a food allergen has been ingested, but NO SYMPTOMS		☐ Epinephrine	☐ Antihistamine
• If stung by a bee, but NO SYMPTOMS		☐ Epinephrine	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat †	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung †	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart †	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other †	________________________________	☐ Epinephrine	☐ Antihistamine
• If a reaction is progressing (several of the above areas affected), give:		☐ Epinephrine	☐ Antihistamine

† Potentially Life Threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject IM (intramuscular) as circled: EpiPen® EpiPen Jr.® Twinject 0.3 mg® Twinject 0.15 mg®

Antihistamine: Give____

medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

♥ STEP 2: EMERGENCY CALLS ♥

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ______________________________ Phone Number: ______________________________
3. **EMERGENCY CONTACTS: Name/Relationship** **Phone Number(s)**

a. ______________________________ 1.) ____________________ 2.) ____________________

b. ______________________________ 1.) ____________________ 2.) ____________________

c. ______________________________ 1.) ____________________ 2.) ____________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE MY CHILD TO MEDICAL FACILITY!

☐ Student has been instructed in the proper use of auto-injectable epinephrine, has demonstrated proper use and may carry his/her own auto-injectable epinephrine at school.

☐ Student should **NOT** carry his/her auto-injectable epinephrine at school.

Parent/Guardian Signature ____ Date ____________________

Physician/Prescriber Signature ____ Date ____________________

Physician/Prescriber PRINTED Name________________________ Phone________________ FAX________________

Student's Name: ____________________________________ School: ______________________ Teacher: _______________

ALLERGY TO: ____

Does student have permission to carry and self-administer his/her own auto-injectable epinephrine? ________YES ________NO

Plan for lunches if food allergy:
Separate table: ________YES ________NO
Student may purchase food at school and in the cafeteria: ________YES ________NO
Other:

Plan for snacks if food allergy:
Parent will provide snacks for: _________each day _________parties
Other:

Plan for field trips:
Parent will attend: ________YES ________NO
In the absence of the parent, the principal's designee who has been trained in the administration of epinephrine will attend the field trip to provide care and administer epinephrine as required.
Other:

Plan for transportation to and from school:
Epinephrine will **not** be provided on bus unless student has permission to carry and self-administer his/her auto-injectable epinephrine.
The Transportation Department will be informed of student's allergic condition and has radio communication with bus drivers.
Other:

Plan for instructing administration and instructional staff:
School nurse will share allergy health care plan information with administration and instructional staff.
A registered nurse will provide training in anaphylaxis and epinephrine administration to unlicensed personnel designated by the principal to administer medication in the absence of the nurse.
Other:

Plan for notifying substitutes:
Teacher is responsible to share allergy health care plan information with substitutes.

Additional Instructions:

Allergy Health Care Plan and Medication Administration Authorization

I, ____, parent or legal guardian of ______________________________, request that the principal's designee at ________________________________ School administer the prescribed medication and provide care to my child as indicated on the *Allergy Health Care Plan* dated __________________________. I give the principal's designee permission to contact the licensed prescriber if necessary. In signing this form, I am agreeing to hold the school and its personnel free from any legal action that might arise from this arrangement.

I also understand that I am to abide by the school division regulations as stated below:

- It is my child's responsibility to come to the clinic to take his/her medication.
- Parent or guardian must bring medication into school office or clinic. Medication cannot be transported on buses or by students.
- The first dose of a new medication should be given at home.
- Prescription medication must have a current prescription label that corresponds with the written authorization.
- Any changes in a medication require a new written authorization and corresponding change in the prescription label.
- Parent or guardian must provide medications/equipment required to administer medications or provide special medical care.
- Left over medication must be picked up at the end of the school year or it will be discarded.

- Students with a diagnosis of anaphylaxis (severe allergic reaction) may possess and self-administer auto-injectable epinephrine during the school day, at school-sponsored activities, and while on the bus or other school property provided the following conditions are met:
  - ✓ The student must have written consent from a parent or guardian **and** from a physician or nurse practitioner that identifies the name, dosage and frequency of medication and circumstances which warrant such medication to be self-administered.
  - ✓ The physician must confirm that the student demonstrates ability to safely and effectively self administer medication;
  - ✓ The parent must provide an individualized health care plan including emergency procedures for any life-threatening conditions. (Completion of this form fulfills this requirement).
  - ✓ The permission to possess and self-administer auto-injectable epinephrine shall be effective for one year, defined as 365 calendar days, and must be renewed annually.
  - ✓ The parent or guardian will be notified by a school official before any limitations or restrictions are imposed upon a student's possession and self-administration of auto-injectable epinephrine.
  - ✓ It is the student's responsibility to notify a teacher or school health official after self administering medication.

I approve this *Allergy Health Care Plan* for my child. I give permission to share information about my child's allergic condition with the school nurse, teachers, principals, office staff, guidance, bus driver/transportation and cafeteria manager as appropriate.

Parent/Guardian Signature ____ Date ______________________

Parent/Guardian PRINTED Name ____

Home Phone _____________________ Work Phone ____________________ Cell Phone ____________________

School Use:

Health care plan information provided by _____________________________________ to the following staff:

Names of Persons and Date	*Names of Persons and Date*