School Year: _____

Model Laboratory School

SCHOOL HEALTH DIVISION
521 Lancaster Ave.
Richmond, KY 40475
(859) 622-8575
(859) 622-6658

PARENT PACKET – EPI-PEN

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are the forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information 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 student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse at your student's school:

- **Emergency Action Plan**
- **Allergy Questionnaire**
- **Physician and Parent Authorization for Epi-Pen Medication Administration**
- **Food Services Modification Form (if needed)**

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

Please call the School Health Services program at 622-8575 if you have any questions.

LIFE-THREATENING ALLERGY EMERGENCY ACTION PLAN

School Year: _____

(This form will be made available to teachers and appropriate school staff.)

Student's Name: _____ DOB:___ / ___ / ___

School: _____ Teacher: _____ Grade: _____

Place Student's Picture Here

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

Address/Zip Code: _____

Doctor: _____ Phone #: _____ Hospital of Choice: _____

TYPICAL SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
☛ **MOUTH**	Itching and swelling of the lips, tongue, or mouth.
☛ **THROAT**	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
☛ **SKIN**	Hives, itchy rash, and/or swelling about the face or extremities.
☛ **GUT**	Nausea, abdominal cramps, vomiting, and/or diarrhea.
☛ **LUNG**	Shortness of breath, repetitive coughing, and/or wheezing.
☛ **HEART**	"Thready" pulse, "passing-out"

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

STUDENT'S ALLERGY IS TO: _____

STUDENT'S TYPICAL REACTION: _____

STUDENT'S OTHER KNOWN ALLERGIES: _____

ACTION TO BE TAKEN:

1. If ingestion/exposure is suspected, give: _____
   Medication/Dose/Route
   _____
   Medication/Dose/Route
2. Location of Medication/Epi-Pen: _____
3. Call Rescue Squad (622-1111) if Epi-Pen is used.
4. Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

   Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

   Or call Emergency Contact from list below if unable to reach Parent/Guardian.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENT/GUARDIAN(S) CANNOT BE REACHED!

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS (School Use Only)
1. _____ **Relation:** _____ **Phone:** _____ **2.** _____ **Relation:** _____ **Phone:** _____ **3.** _____ **Relation:** _____ **Phone:** _____	**1.** _____ **Room:** _____ **2.** _____ **Room:** _____ **3.** _____ **Room:** _____

REVIEWED BY: _____ *RN* *DATE:* _____

ALLERGY QUESTIONNAIRE

School Year: _____

Student's Name: _____ **DOB:**___ **/** ___ **/** ___ **SCHOOL:** _____

1. Allergies: _____

2. Date of student's last allergic episode? ___ / ___ / ___ ☐ Never had an allergic episode
   What happened?_____

3. Diagnosed by skin/blood testing? ☐ Yes ☐ No Date ___ / ___ / ___ Physician's Name: _____

4. Has student ever been hospitalized for an allergic episode? Yes ☐ No ☐ Date ____ / ____ / ____

5. Does your student react when they eat the above allergen? ☐ Yes ☐ No
   Type of reaction: ☐ Stomachache ☐ Itching ☐ Hives ☐ Itchy throat
   ☐ Cough/Wheezing ☐ Anxiety/Restlessness ☐ Swollen lips or tongue
   ☐ Other_____

6. If this is a food allergy, do you plan to send lunch each day for your student? ☐ Yes ☐ No

7. Does your student react when they touch (**or are bitten/stung by, if Insect**) the above allergen? ☐ Yes ☐ No
   Type of reaction: ☐ Rash ☐ Itching ☐ Hives ☐ Itchy throat ☐ Cough/Wheezing
   ☐ Anxiety/Restlessness ☐ Swollen lips or tongue
   ☐ Other_____

8. Does your student react when they smell or inhale the above allergen? ☐ Yes ☐ No
   Type of reaction: ☐ Stomachache ☐ Itching ☐ Hives ☐ Itchy throat
   ☐ Cough/Wheezing ☐ Anxiety/Restlessness ☐ Swollen lips or tongue
   ☐ Other_____

9. Can your student sit near someone eating the allergen? ☐ Yes ☐ No

10. Does your student know what the allergen looks like and how to avoid it? ☐ Yes ☐ No

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

12. Can the school send a letter home notifying the classroom about your student's allergy in order to decrease the chances the allergen will be brought to school by a classmate? ☐ Yes ☐ No

13. List the Medication(s) your student takes for allergic reactions (please fill out the attached Medication Authorization Form if needed) *

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____

14. Additional comments: _____
    _____

REVIEWED BY: _____ *RN* *DATE:* _____

School: _____ **School Year:** _____

PHYSICIAN AND PARENT/GUARDIAN AUTHORIZATION FOR EPI-PEN MEDICATION ADMINISTRATION

The Board of Education of Madison *County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.*

The undersigned Parent/Guardian does hereby consent to the intervention of the volunteer staff member in accordance with the Physician's instructions. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

PHYSICIAN ORDER FOR EMERGENCY ACTION PLAN

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 622-8575 *or by mail:* Model Laboratory School, 521 Lancaster Ave., Richmond, KY 40475.

STUDENT'S NAME: _____ **DOB:** _____

ALLERGEN: _____

STUDENT'S TYPICAL REACTION: _____

STUDENT'S OTHER KNOWN ALLERGIES: _____

ACTION TO BE TAKEN:

1. If ingestion/exposure is suspected, give: _____
   Medication/Dose/Route
   _____
   Medication/Dose/Route
2. Call Rescue Squad (622-1111) if Epi-Pen is used.
3. Notify Parent/Guardian or Emergency Contact.

I believe this student is able to carry and administer his or her own medication at the appropriate time and in the appropriate way. This student has been instructed on the indication for medication usage and methods of administration. Please check: Yes ☐ No ☐

X _____ _____
(Physician's Signature) Date Signed

_____ _____
(Physician's Name - Printed) Telephone Number

PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication. See above and below.

PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent/Guardian of* _____ ***request that a *trained staff member administer*** *the above medication to the student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the* Madison *County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.*

☐ *I, the undersigned Parent/Guardian of* _____ ***give consent for **my student to self-administer*** *the above medication(s). I understand the* Madison *County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance.* **The School Nurse reserves the right to monitor the student periodically throughout the year.**

**** Parent/Student are responsible to have medication available at school.***

***** Self-Administered medication not provided or monitored by school staff.***

X _____ _____
(Parent/Guardian's Signature) Date Signed

REVIEWED BY: _____ ***RN*** ***DATE:*** _____

FOOD SERVICES MODIFICATION

School Year: _____

EATING AND FEEDING EVALUATION

This form must be completed and signed by a Physician if your student requires a dietary restriction. (i.e. no peanut butter, no strawberries, etc.) OR a food substitute (i.e. allergic to cow's milk – substitute soy milk). This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.) This form is good for one school year and must be completed and signed by student's Physician to reverse a previous accommodation (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.)

PART A			
Name of Student:		**Date of Birth: _____ / _____ / _____**	
Allergies:			
Name of School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? If Yes, describe the major life activities affected.		☐ **Yes**	☐ **No**
Does student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed Physician.		☐ **Yes**	☐ **No**
IF STUDENT DOES NOT REQUIRE SPECIAL MEALS, PARENT/GUARDIAN CAN SIGN AT THE BOTTOM OF THIS FORM AND RETURN THE FORM TO THE SCHOOL'S FOOD SERVICE.			
PART B			
List any dietary restrictions or special diet:			
List any allergies or food intolerances to avoid:			
List foods to be substituted:			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." **Cut up or chopped into bite-size pieces:** **Finely ground:** **Pureed:**			
List any special equipment or utensils that are needed:			
Indicate any other comments about student's eating or feeding patterns:			
Parent/Guardian's Signature: _____		**Date: _____ / _____ / _____**	
Physician's Signature: _____		**Date: _____ / _____ / _____**	

REVIEWED BY: _____ ***RN*** ***DATE:*** _____

ROLES IN THE MANAGEMENT OF STUDENTS WITH LIFE-THREATENING ALLERGIES

PARENT/GUARDIAN'S RESPONSIBILITIES

- Notify the school of the student's allergies prior to the start of the school year – fill out and return the packet sent in the mail OR as soon as possible after a new diagnosis.
- Participate in developing an emergency plan for your student with the School Nurse.
- Provide a list of foods and ingredients to avoid.
- Work with the school team to develop a plan that accommodates the student's needs throughout the school including in the classroom, in the cafeteria, in after-care programs, during school-sponsored activities, and on the school bus.
- Provide written medical documentation, instructions, and medications as directed by a physician.
- Attach a current photograph of your student to the forms sent to you in the mail.
- Provide properly labeled medications and replace medications after use or upon expiration.
- Decide if additional epinephrine auto-injectors will be kept for the student in the school.
- Educate the student in the self-management of their food allergy including:
  * Safe and unsafe foods
  * Strategies for avoiding exposure to unsafe foods
  * Symptoms of allergic reactions
  * How and when to tell an adult they may be having an allergy-related problem
  * How to read food labels (age appropriate)
  * Review policies/procedures with the school staff, the student's Physician, and the student (if age appropriate) after a reaction has occurred.
- Provide emergency contact information and notify school immediately if information changes!
- Provide the School Nurse with a Physician's Statement if student no longer has allergies.
- Leave a bag of "Safe Snacks" in your student's classroom so there is always something your student can choose from during an unplanned special event.

SCHOOL'S RESPONSIBILITY

- Be knowledgeable about and follow applicable federal laws including ADA, IDEA, Section 504, and FERPA.
- Review the health records submitted by Parent/Guardian(s) and Physicians.
- Include food-allergic students in school activities. Students should not be excluded from school activities solely based on their food allergy.

- Assure that all staff who interact with the student on a regular basis understands food allergy, can recognize symptoms, knows what to do in an emergency, and works with other school staff to eliminate the use of food allergens in the allergic student's meal, educational tools, arts and crafts projects, or incentives.
- Be prepared to handle a reaction and ensure that there is a staff member available who is properly trained to administer medications during the school day.
- Review policies/prevention plan with the core team members, Parents/Guardians, student (age appropriate), and Physician after a reaction has occurred.

- Take threats or harassment against an allergic student seriously.
- Discuss field trips with the family and food-allergic student to decide appropriate strategies for managing the food allergy.

RESPONSIBILITIES OF THE CLASSROOM TEACHER

- Participate in in-service training offered by the School Nurse that addresses the student with food allergies.
- Be aware of allergens that cause life-threatening allergies such as foods, insect stings, medications, latex and have a copy of the student's Emergency Plan.
- Know how to manage an emergency and administer an epinephrine auto-injector.
- Be sure volunteers, student teachers, aides, specialists and substitute teachers are informed of the student's allergies and necessary safeguards.
- Leave information in an organized, prominent, and accessible format for substitute teachers.
- Educate classmates to avoid endangering, isolating, stigmatizing, or harassing students with food allergies. Be aware how the student with food allergies is being treated; enforce school rules about bullying and threats.
- Inform parents of any school events where food will be served.
- Never question or hesitate to act if a student reports signs of an allergic reaction.
- Use stickers, pencils, or other non-food items as rewards instead of food to reduce the risk of reactions.

FIELD TRIPS

- Notify the School Nurse two weeks prior to a scheduled field trip and include date, time and location.
- Ensure epinephrine auto-injectors and instructions are taken on field trips.
- Ensure that a functioning cell phone or other communication device is taken on field trip.
- Review plans for field trips – avoid high-risk places.
- Know where the closest medical facilities are located.
- Invite parents of a student at risk for anaphylaxis to accompany their student on school trips in addition to a chaperone. However, the student's safety or attendance must not be conditioned on the parent's presence. Parent/Guardian must complete a background check prior to field trip in compliance with Madison County Public School Policy.
- Consider ways to wash hands before and after eating.
- One to two people on the field trip should be trained in recognizing symptoms of life-threatening allergic reactions, trained to use an epinephrine auto-injector, and trained in emergency procedure.

CAFETERIA RESPONSIBILITIES

- Read all food labels and recheck routinely for potential food allergies.
- Train all food service staff and their substitutes to read product food labels and recognize food allergens.
- Review and follow sound food handling practices to avoid cross contamination with potential food allergens.
- Strictly follow cleaning and sanitation protocol to avoid cross-contamination.
- Be aware of which students have food allergies, know how to recognize food allergy reaction and how to follow emergency care plan.

SCHOOL NURSE RESPONSIBILITIES

- Prior to entry into school or immediately after diagnosis, develop an emergency plan for the student.
- Assure the emergency plan includes the student's name, allergens, symptoms of allergic reactions, emergency procedures, and required signatures. Familiarize teachers by the opening of school if possible.
- Preferably before school starts, notify all staff who come in contact with the student with allergies - including principal, teachers, specialists, food service personnel, aids, PE teacher, bus driver, etc.
- Train two office staff personnel in emergency medication administration prior to the start of school and other appropriate staff members within a month of the start of school.
- Place a medical alert in Infinite Campus.
- Provide information about students with life-threatening allergies to all staff on a need-to-know basis (including bus drivers),
- Conduct in-service training and education for appropriate staff regarding a student's life-threatening allergens, symptoms, risk reduction procedures, emergency procedures, and how to administer an epinephrine auto-injector.
- Document which school personnel have been trained.

STUDENT'S RESPONSIBILITIES

- Should not trade food with others if has food allergy.
- Should not eat anything with unknown ingredients or known to contain any allergen, if has food allergy.
- Should be proactive in the care and management of their food allergies and reactions based on their developmental level.
- Should notify an adult immediately if they eat something they believe may contain the food to which they are allergic.
- Wash hands before and after eating.
- Learn to recognize symptoms of an allergic reaction.
- Know where the epinephrine auto-injector is kept and how to access it if not kept on person.
- Carry his/her own epinephrine auto-injector if age appropriate, and if Physician and parent have completed appropriate forms for him/her to carry and administer epinephrine.

It is important that children take on more responsibility for their food allergies as they grow older and are developmentally ready. Consider teaching them to:

- Communicate the seriousness of the allergy.
- Communicate symptoms as they appear.
- Read labels.
- Carry own epinephrine auto-injector.
- Administer own epinephrine auto-injector and be able to train others (i.e., classmates, friends, etc.) in its use.

SEVERE ALLERGIC REACTIONS

CHILDREN MAY EXPERIENCE DELAYED ALLERGIC REACTIONS UP TO 2 HOURS AFTER FOOD INGESTION, BEE STING, ETC.

*****GIVE EPIPEN IMMEDIATELY IF **ordered by MD** and THE ALLERGEN WAS DEFINITELY EATEN OR KNOWN EXPOSURE, EVEN IF NO SYMPTOMS*****

SEVERE ALLERGIC REACTION symptoms which may include:

LUNGS: Short of breath, wheezing, constant cough	**HEART: Pale, blueness around mouth or eyes**	**SKIN: Hives ALL over body, swelling of face and/or neck**	**GUT: Repetitive vomiting or severe diarrhea**
THROAT: Tight, hoarse, trouble swallowing	**MOUTH: Significant swelling of the tongue and / or lips**	**OTHER: Feeling something bad is about to happen, confusion, loss of consciousness**	**OR: COMBINATION OF MILD OR SEVERE SYMPTONS FROM DIFFERENCT PARTS OF THE BODY**

1. **CALL 622-1111 IMMEDIATELY.**
2. Contact School Office/School Nurse and send for immediate help. (EPI-PEN/ CPR/First Aid).
3. Trained personnel should ***GIVE STOCK EPI-PEN OR EPI-PEN*** prescribed by primary care provider.
4. Principal/Designee notifies parent/guardian.
5. Monitor and remain with student. Provide emergency care until 911 arrives.
6. Move individual only for safety reasons.

Mild Allergic Reaction symptoms which may include:

NOSE: itchy, sneezing, sudden runny nose	**MOUTH: itchy mouth**	**SKIN: A few hives or rash in one area, mild itch**	**GUT: Mild nausea/discomfort**

1. Notify School Nurse/ School Office.
2. School Nurse or Trained Personnel give STOCK oral generic antihistamine ***(BENEDRYL)*** or if ***(BENEDRYL)*** prescribed by primary care provider.
3. Principal/ Designee notifies parent/guardian.
4. **Observe for symptoms of severe allergic reaction.**

NEVER LEAVE STUDENT ALONE

Madison County School District School Health Program

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____Student age: _____Date of Birth:_____

Grade:_____Homeroom/Classroom:_____

TO BE COMPLETED BY PARENT / GUARDIAN

************(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)************

Name of medication: _____Reason for medication:_____

ALLERGIES:_____ Any OTHER Condition(s):_____

Form of medication/treatment:_____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school:_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other Instrructions:_____

Parent or Guardian Signature_____Date:_____

Health Care Provider Name_____

Address:_____ Phone:_____ FAX:_____

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date:_____Signature:_____ Relationship:_____

Home phone:_____ Work phone:_____ Emergency or CELL phone:_____

TO BE COMPLETED BY Health Care Provider

♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY♦♦♦

This student is capable, responsible, and demonstrated self-administration of the above medication:

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No** **Any restriction(s):_____**

The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____Date_____

Physician or Authorized Provider

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.** **MCBE 1 (7-2014)**

Adapted from the Academy of Pediatrics