CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Individualized Food Allergy Health Care Plan
SCHOOL YEAR: _____

Student Name: _____

1. School Nurse/ Parent will inform and review action plan with teachers, food service employees, first responder in school building.
2. All snack/treats brought to classroom will be pre-packaged with ingredients plainly listed.
3. A school menu will be available to parents to review daily school lunches/breakfast
4. Teacher/staff will call parent to question whether a particular food product is safe if unsure.
5. If food item provided by classmate has unknown content, allergic student will be instructed not to ingest it.
6. At snack and lunch time, supervising staff will monitor student activity to prevent sharing of foods or exposure in any way (topical, airborne, ingestion) between allergic student and classmates.
7. A separate table will be available for student with food allergy during meals/snacks
8. Student will be instructed to tell staff immediately if exposure via ingestion, topical, etc.
9. Student will be taught to read labels, to identify sources of food allergens and advocate for him/herself regarding the food allergy as developmentally appropriate. This will be done by parent, school nurse, teachers as the opportunity arises.
10. **All students with serious/life-threatening allergies will have the attached: "FOOD ALLERGY ACTION PLAN" completed at the beginning of each new school year.** This includes the med orders as well.
11. List any other interventions specific to student:_____
    _____

****EMS (911) will be notified if Epi-Pen given in response to severe allergic reaction per Campbell County Policy****

Trained School Personnel:

1._____ **Room:** _____

2._____ **Room:** _____

3._____ **Room:** _____

Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

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

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**: (**To be determined by physician authorizing treatment)	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the 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 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 intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: 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 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
1. _____	1.)_____	2.) _____
2. _____	1.)_____	2.) _____

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

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room _____

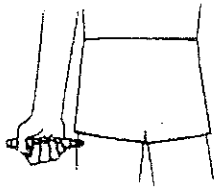
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**

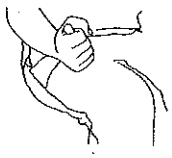


- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**

- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**



<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**

- **Slide yellow collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

June/2007

CAMPBELL COUNTY SCHOOLS

Authorization to Carry/Self-Administer Medication

Pursuant to the laws of the Commonwealth of Kentucky and Campbell County Schools Board Policy, students may be granted permission to carry and self-administer medication only for emergency use during school hours and during school sponsored activities. This is limited to medication for treatment of asthma, severe allergic reaction, or diabetes. The student must have training in the proper use of the medication named and be responsible for safe use.

Name of Student_____ DOB_____ School_____ Grade___

Condition for which Medication is prescribed_____

Name of Medication_____

Dose of Medication and route_____

Time and Indication for Administration_____

Side effects to be noted/reported_____

Other recommendations: _____

Length of time Medication is authorized: From_____ to_____ (Limit of 1 school year)

Date Authorization received by school: _____

In my opinion, this student shows capability to carry and self-administer this medication as ordered above.

Physician Signature_____ Printed Name_____
Phone number_____ Date_____

****

Parent/Guardian Authorization

I request that my child be permitted to carry and self-administer the medication ordered above. I understand the medication must be in its original prescription container. I accept responsibility for this permission and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

Signature of Parent/Guardian _____ Date _____

Revised 4/04

Campbell County Schools Health Services

Consent Form for Administering Medication at School

Student's Name _____ Grade _____

Name of Medication _____

Dosage _____

Time(s) to be Given _____

Route of Administration _____

Diagnosis or Reason for Medication to be Given _____

Possible Side-Effects: _____

Student's Allergies: _____

Name of Prescribing Doctor _____ Phone _____

_____ _____

Signature of Prescribing Doctor Date

I request my child be permitted to take medications as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____

Signature of Parent/Guardian Date

_____

Name of School Submitted to

Revised 7/09

Campbell County Schools Health Services

Consent Form for Administering Medication at School

Student's Name _____ Grade _____

Name of Medication _____

Dosage _____

Time(s) to be Given _____

Route of Administration _____

Diagnosis or Reason for Medication to be Given _____

Possible Side-Effects: _____

Student's Allergies: _____

Name of Prescribing Doctor _____ Phone _____

_____ _____

Signature of Prescribing Doctor Date

I request my child be permitted to take medications as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____

Signature of Parent/Guardian Date

_____

Name of School Submitted to

Revised 7/09

Campbell County Schools Health Services

Administration of Medication at School

Since it is recognized that some students are able to attend school because of the effectiveness of medications in the treatment of chronic disabilities and illnesses, this procedure has been adopted to help insure safe administration of medications in school.

A. No medication, prescription or over-the-counter, may be administered to students by an employee of the Campbell County Board of Education unless the **Consent Form for Administering Medications at School** form is filled out and signed by both the physician and parent/guardian. No handwritten notes by parent/guardian will be accepted.

B. Only doses of medication that cannot be administered at home will be given at school. Medication will not be administered at school due to convenience.

C. Any student who is required to take medication during regular school hours shall comply with the following:

1. No medication will be supplied by the school.
2. Prescription medications shall be brought to school in the original container that is properly labeled with the following information:
    a. Name of student
    b. Name of medication
    c. Dosage of Medication
    d. Time medication is to be administered
3. Nonprescription medication must be brought to school in original container and will only be administered with a physician signature on the appropriate Campbell County Schools Medication Consent form.
4. No medication, prescription or nonprescription, may be transported by the student on the school bus.
5. Medications should be provided in the form that it is to be administered. School staff will not divide tablets, etc.
6. School staff will not administer the first dose of any newly prescribed medication.
7. All medication will be kept in the school office in a specified safe place. Students are not permitted to have medication in their possession.
8. Self-managed/self-carry administration of emergency medication (insulin, inhalers, Epi-Pens) will be permitted with written authorization of parent and physician on the appropriate Campbell County Schools Self-Carry form.
9. It is the student's responsibility to comply with the doctor's order concerning administration of medications. Upon receipt of the signed consent form, school personnel will endeavor to assist students with medications.
10. All prescription medication amounts will be verified by nurse and parent/guardian upon initial arrival to office.
11. Every dose of medication administered by school personnel shall be recorded on a prescribed form.
12. Medications that contain narcotics or sedation for pain will NOT be administered at school to help Insure student safety.

******School personnel responsible for administration of medications will refuse to administer medication if the above guidelines are not followed. In such situations, the parent/guardian will be notified.*******

AGREEMENT FOR THE ADMINISTRATION OF EMERGENCY CARE

The undersigned parent/guardian of _____
a pupil in the Campbell County Public Schools, has advised the Board of Education of Campbell County that his/her child named above suffers from a medical condition which may be life threatening unless immediate emergency care is provided in a crisis which may arise from the child's health problem.

Accordingly, the Board of Education of Campbell County has adopted a procedure wherein a member of the staff of the school the child 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 that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the child'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 instructions contained in the attached letter from the child's physician. 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.

Dated at Alexandria, Kentucky, this the _____ day of _____. _____
(Day) (Month) (Year)

X _____
(Parent/Guardian Signature)