Homer Rice
Administrator

LEON COUNTY SCHOOLS

Jackie Pons
Superintendent

Dear Parent/Guardian,

Your child has been identified as having a food and/or insect allergy that may require immediate medication (an antihistamine and/or EpiPen) if exposed to an allergen. Enclosed are the Allergy Action Plan and related medical forms for the 2012-2013 school year to be **completed by you and your child's health care provider**. These documents provide a guide for your child's care during the school day. The Registered Nurse assigned to your child's school will provide training to designated school personnel based on this information.

The following forms need to be completed and returned to the school health room as soon as possible:

- Allergy Action Plan (completed **and** signed by your child's health care provider)
- Consent for Sharing of Medical Information (check off each applicable agency **and** add other provider if not listed)
- Medication Permission Forms (completed for each medication prescribed)
- Specialized Health Care Procedure Authorization Form (completed **and** signed by parent **and** prescribing physician)

Additionally, the following are required if your child carries his/her emergency medication:

- Authorization for Carrying Medication to include Epi-Pen **and/or** antihistamine (completed **and** signed by your child's health care provider)
- All medications must be properly labeled ***for your child*** with a prescription label including the child's name, name of the medication, dosage, time(s) of administration and physician name

Remember to keep copies of these documents for your records!

If you have any questions, please feel free to contact Leon County Health Department School Health Division at 606-8150.

Sincerely,

Nancy Cooper, RN, BSN, NCSN

Nancy Cooper, RN, BSN, NCSN
School Health Coordinator
Leon County Health Department

Child Specific Training Log

School Year: _____

Student Name: _____ School: _____

Type of Training: _____

Date	Name/Title	RN Signature

LEON COUNTY SCHOOLS
Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ School: _____ DOB: _____
Grade: _____ Teacher/Homeroom: _____

ALLERGY TO: _____

Asthma Dx? Yes* ☐ No ☐ *Higher risk for severe reaction

To be determined by physician authorizing treatment

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication:**	
▪ If exposed to allergen, but ***no symptoms***:		☐ EpiPen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other †	_____	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening

DOSAGE:

Epinephrine: Inject intramuscularly (circle one or list) EpiPen EpiPen Jr. Other: _____

Antihistamine: Give _____
medication/dose/route

Other: Give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contacts:

Name/Relationship	Phone Numbers
1. _____	h _____ w _____ c _____
2. _____	h _____ w _____ c _____
3. _____	h _____ w _____ c _____

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

Parent/Guardian Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____
(Required)

LOCATION OF EPIPEN: _____

Reviewed By LCHD School RN Signature: _____ Date: _____

Specialized Health Care Procedure:

Administering Emergency Injectable Medication (EpiPen)

Purpose: Anaphylaxis is an allergic reaction of the body to a foreign protein or drug. Sudden and severe reactions in the body affect the heart and respiratory systems. School personnel need to know which students have been prescribed an EpiPen for allergic reactions and to be aware of where these students are during the school day to react calmly but swiftly in an allergic reaction situation.

Requirements: Parents/guardians are required to complete and sign a medication permission form at the student's school. An Allergy Action Plan, completed by the prescribing physician, must be signed by the physician and the parent. Parents/guardians are required to supply all medication and equipment needed to administer the medication.

Personnel authorized to perform procedure: Can be performed by an RN or LPN, or by any designated staff member trained by the nurse. Training will be reviewed on a yearly basis.

Equipment required: EpiPen syringe with prescription information printed on the box.

Special Considerations: Administration of an emergency injectable (EpiPen) is done to relieve a life-threatening situation. It is important that the rescue squad ("911") be called to assess the student's reponse to the medication or to determine further needs. The student should never be left alone during this situation.

Procedure:

1. Depending on the status of the student, either have him/her brought to the clinic/office foe care, or have the trained person with the EpiPen go to the student's location.
2. Identify the need for administration of the EpiPen according to the student's individual Allergy Action Plan. Symptoms may include any of the following: shortness of breath, hives, itching, redness of the skin, sneezing, coughing, wheezing, constriction in chest or throat, difficulty swallowing, confusion, and a feeling of impending disaster.
3. Have someone call 911 and tell them that a student is having a severe allergic reaction and you are about to administer an EpiPen.
4. Verify that the name on the prescription box is the same as that of the student to receive the injectable.
5. Administer the EpiPen with the student lying down:
   - Pull off the blue safety cap.
   - Hold the orange tip near the skin on the upper outer thigh.
   - Swing and jab firmly into outer thigh until auto-injector mechanism functions and hold in place for 10 seconds. (Can go through clothing.)
   - Massage injection area for 10 seconds..
   - Place used EpiPen in storage container and give to EMS.
6. Notify parents/guardians and prepare for the arrival of paramedics. Be prepared to perform CPR if needed.
7. Follow up later in the day with the parents/guardians to check on the condition of the student, and to be sure they bring another EpiPen to school before the student returns.

Parent Authorization for Specialized Health Care Procedure

I, the undersigned, who is the parent/guardian of _____ request that the following health care service:

Administering Emergency Injectable Medication (EpiPen)

be administered to my child. I understand that a trained designated staff member will be performing this procedure. It is my understanding that in performing this procedure, the designated person(s) will be using a standardized procedure which has been approved by our physician. I will notify the school immediately if the health status of our child changes, I change physicians, or there is a change or cancellation of the procedure.

Signature of parent/guardian _____

Date _____

Physician's Order for Specialized Health Care Procedure

Student's Name _____ DOB _____

Procedure: **Administering Emergency Injectable Medication**

Check one:

_____ I have reviewed the Health Care Procedure and approve of it as written.

_____ I have reviewed the Health Care Procedure and approve of it with the attached amendments.

_____ I do not approve of the Health Care Procedure. A substitute procedure is attached.

Duration of the procedure (not to exceed current school year): _____

Physician's Signature: _____ **Date:** _____

LEON COUNTY SCHOOLS
MEDICATION PERMISSION FORM
(One form for each medication)

I hereby certify that it is necessary for _____ Date of Birth: _____
(Full Name of Student - List all names used by student)
Teacher/Homeroom: _____ Grade Level: _____
to be given the medication listed below during the school day, including when he/she is away from school property on official school business. Without this medication, he/she will not be able to attend school.

Signed form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc.) Only FDA-approved medicines will be accepted.

Name of Medication: _____

Reason for Medication (Diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning Date: _____ Ending Date: _____ Amount of Liquid or Count of Pills: _____

Emergency Telephone Numbers:

Parent/Guardian: _____ H: _____ W: _____ C: _____

Parent/Guardian: _____ H: _____ W: _____ C: _____

Doctor's Name: _____ Phone: _____

Prescription and non-prescription medication shall come in the original container and shall be labeled. Changes in the medication times or dosage can only be made by written prescription from the physician, which may be faxed to school health personnel. This permission form is valid for the current school year only.

Parents are requested to pick up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded.

I hereby consent to protected health information being used and disclosed to carry out treatment, payment, or health care operations of my child. I understand that the Leon County School District may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment, payment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby authorize the School Board of Leon County, Florida ("LCSB") and Leon County Health Department ("LCHD"), and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his or her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration. I hereby release, indemnify, and hold harmless LCSB and LCHD and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, LCHD and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____
(Date) (Parent/Guardian Signature)

LEON COUNTY HEALTH DEPARTMENT

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year_____

Student's Name: _____
DOB: _____
School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from Leon County Health Department, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial <u>all</u> that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [X] Leon County Health Department
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____
Signature of Parent/Guardian or eligible student

_____
Date

Revised 5/12