Emergency Plan of Action for: Life Threatening Allergies (List Allergens)

<table>
<tr><td>Student Name:</td><td>Class/Grade:</td></tr>
<tr><td>Parent Name:</td><td>Parent Phone:</td></tr>
<tr><td>Physician Name:</td><td>Physician Phone:</td></tr>
<tr><th>If you see this!</th><th>Do this!</th></tr>
<tr><td><u>LTA</u>= Life Threatening Allergies;
❑ FOOD <u>allergies</u> involve the interaction between food and the immune system. The amount of food needed to cause an allergic reaction varies. Symptoms can show up on the skin, respiratory tract, GI, or cardiac. The most serious reaction is anaphylaxis.
❑ INSECT <u>allergies</u> involve the interaction between an insect's venom and the immune system.</td><td><u>Prevention</u>:
❑ Children should not share <u>food</u> at meals or snack, whether brought from home of provided by the school cafeteria. Classroom personnel & student will help to monitor or avoid exposure to the allergens. Allergen-free seating for meals helpful.
❑ Be aware of the environment and where specific <u>insects</u> may be or have been sighted. Monitor exposure to those areas and report sighting to school custodial services if they occur in play areas.</td></tr>
<tr><td>If the student comes in contact with these allergens:
____
____
____
❑ ______Oral ingestion
❑ ______Inhalation
❑ ______Contact of skin</td><td>1. Call for assistance from Health Assistant or Administration
2. Call Parents
3. Observe for these symptoms:
● Sense of tightness in the throat
● Light headed / faint
● Nausea & stomach discomfort
● Anaphylactic Shock</td></tr>
<tr><td>If the student show signs of anaphylactic shock:
● Tingling sensation and/or itching
● Hives
● Swelling of throat and mouth
● Difficulty swallowing or speaking
● Difficulty breathing
● Abdominal cramps, nausea, and vomiting
● Sudden feeling of weakness (indicating a drop in blood pressure)
● Disorientation
● Collapse and unconsciousness</td><td>☐ If Benadryl is the only medication to be given please indicate here.
**Over the counter form with dosage & doctor signature must accompany this form.
<hr>1. Call EMS/911
2. Activate CPR/AED Team
3. Notify Parents of Status
4. Administer <u>Epinephrine auto-injector</u> as directed by Physician's Orders
5. Observe for 15 minutes
6. If breathing & swelling of throat has not improved administer 2nd dose of <u>Epinephrine auto-injector</u></td></tr>
<tr><td>If student is transported by EMS/911</td><td>1. Give EMS emergency card copy
2. Notify parents which hospital student is at.</td></tr>
<tr><td colspan="2">Known Allergies:</td></tr>
</table>

Please attach a copy of the Emergency Card to this form.

<table>
<tr><td colspan="2">If an Emergency occurs:
1. Stay with child
2. Call or have someone else call for the School's Health Assistant, LPN or Registered Nurse
3. Call for the activation of the AED Team to your location, if the student requires CPR or the use of the AED</td></tr>
<tr><td>Principal Signature/Date</td><td>Parent Signature/Date</td></tr>
</table>

SCHOOL HEALTH SERVICES

PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Name: ______________________________________ Student #: _____________ DOB: _____________
Last First Middle

School: ____Grade: ___________

As the parent/guardian of the student named above, I request the principal's designee to administer the medication(s) described below to our/my child at school.

Known Allergies:

Medication	Amount/ Strength	Dose	Med. Exp. Date	Time	Purpose of Medication	Date Begins	Date Ends

Physician's Name:____ Phone Number:_______________________

I understand that the provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s). I hereby authorize School Health Services staff to reciprocally release verbal, written, faxed or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Hillsborough County Public Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I have read the attached guidelines and agree to abide by them.

Please list the medications your child takes at home (include dosage and times).

____

____

Where does the child go after school? ____

PLEASE NOTE EARLY RELEASE DAYS MAY IMPACT ADMINISTRATION OF MEDICATION.

Early release time: 12:00pm Will medication be given? Yes No

_______________________________ _______________________ _______________________
Parent/Guardian Signature Primary Daytime Phone Date

Distribution: Nurse

GUIDELINES FOR ADMINISTRATION OF MEDICATION

It is recognized that medications may be essential for some students. When possible, all medications should be administered at home. If medication must be given at school, the following procedures are required:

1. All medications given at school must be U.S. Food and Drug Administration (FDA) approved for the medical diagnosis.

a. Substances not to be given at school are all unregulated products, such as herbs and food supplements, which are being used as treatments, dietary supplements, or folk remedies.

b. No IV access will be started, flushed, maintained, or discontinued in any circumstance. No medications will be permitted via central venous catheter or peripheral intravenous central catheters (PICC lines or central lines) including antineoplastic agents, investigational drugs, total parenteral nutrition (TPN), blood or blood products, emergency medications, or antibiotics.

2. Oral non-prescription (over-the-counter) or sample drugs will be dispensed only when accompanied by written orders from a physician, APRN, or PA and must be U.S. Food and Drug Administration (FDA) approved for the medical diagnosis. Students may not carry over-the-counter medications at school.

There is one medication EXCEPTION, medication for the self-treatment of diagnosed Headaches, do not require a doctor's order and the student may self-carry (refer to self-carry form).

a. Medication is always to remain in the container in which it was purchased and must be unopened when received by the school.

b. Written parental authorization is needed for all non-prescription drugs.

c. Cough drops will be treated as an over-the-counter medication.

d. Possession of drugs of any kind may lead to serious disciplinary action.

3. No prescription narcotic analgesics are to be dispensed at school. The side effects make it unsafe for students to attend school while medicated with narcotics.

4. A signed statement by the parent/guardian requesting the administration of medication must accompany all medication. The Parent Authorization for Administration of Medication form must be completed before receipt of the medication.

a. New authorization forms will be required when any changes with the orders occur.

b. All medication/procedure forms must be updated annually.

5. Medication must be sent to school by a parent/guardian. a. It is not safe for children to deliver medicine to the school. b. This policy prevents safety concerns of lost or stolen medicines, students sharing medicines with friends, and students taking medicine unsupervised.

6. Medication must be in the original prescription container with the: 1) name of drug, 2) date prescribed, 3) dosage prescribed, and 4) time of day to be taken, any special directions, with student's and physician, APRN, or PA names clearly marked.

a. Medication must remain in the container in which it was originally dispensed.

b. Most pharmacies will provide an extra empty labeled bottle for school for parents if requested when the prescription is filled. A separate prescription bottle should be provided for field trips.

c. No more than a month's supply of controlled medication may be brought in at a time. d. All new prescription refills must remain in original container with current expiration date.

GUIDELINES FOR ADMINISTRATION OF MEDICATION (cont.)

7. All medications and/or supplies received must be documented with the parent/guardian, employee, and witness on the Medication and Supply Intake Form.

a. The amount and date received are to be recorded.

b. The parent/guardian is also required to sign Medication and Supply Intake Form when picking up medication/supplies.

8. The parent/guardian should arrange for a separate supply of medication for the school. a. Medication will not be transported between home and school. i. Exceptions by Florida statutes 1002.20(h)(i)(j)(k) which require a Parent Self Administration Form and a Physician Self Administration Form for: asthma inhalers, EpiPens, pancreatic enzyme supplements, and diabetes supplies and equipment.

9. When any medications are added or discontinued, a new authorization form is required.

10. When medication dosages or times are changed, a new signed authorization form with the correct information must be completed and a new label from the pharmacist or physician, APRN, or PA order/prescription indicating the change must be sent to the school. a. A fax is acceptable.

11. Medication will be stored in a locked cabinet at the school at all times. a. Exceptions by statutes are asthma inhalers, EpiPens, pancreatic enzyme supplements, and diabetic supplies and equipment. Students who self-carry require a Parent Self Administration Form and a Physician Self Administration Form.

12. Since many students receive medication during school hours, a school district employee designated by the principal will administer medication.

a. The Registered Professional School Nurse as permitted by Florida law will train the designated employee. The training of designated staff includes HOST, field trips, and when the student is away from school property on official school business.

b. The medication container with pharmacy label/supplies and paperwork will be sent with the trained staff member, agency nurse, or HOST staff personnel. All medications must be signed out and recorded on the Field Trip Medication Sign Out Sheet.

c. Under no circumstances may medication be transferred from one container to another by anyone other than Registered Pharmacist with the exception of field trips. Clinic staff preparing for field trips will send medication in original container.

13. Liquid medication will be given in a calibrated measuring device supplied by the parent.

14. All medications/supplies must be removed from the school premises within one week of the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. Medications/supplies that are unused and unclaimed will be destroyed following proper disposal procedures.

16. Non-medicated sunscreen and insect repellent may be administered without a prescription, but a parent/guardian authorization form must be completed.

Florida Statue 1006.062 is the reference for the above guidelines.

Authorization for Student to Self-Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: ________________________________

Student's Name: ____ Birth date: ____________________

School: ________________________________

Teacher's Name: ________________________________ Grade / Homeroom ____________________

To be completed by the physician:

Diagnosis:____

____

Medication: ____

The named above student is under my care. I feel that this student has a life-threatening illness and that he/she is capable of and has been instructed in the proper administration of the required medication(s) and/or procedure(s). The student has been instructed in the treatment plan, self-administration of their medication/procedures and has demonstrated the skill necessary to manage their own care. It is understood that at school personnel will not be responsible or liable for the administration of the medication listed above. It is further understood that proper instruction is the use of the medication has been given to the parent and student by you/your staff. The privilege of self-administration of medication can be withdrawn if abused by the student. The student has demonstrated the ability to use the inhaler as prescribed.

Physician Signature: ____ Date: ________________________

Physician Printed Name: ____ Phone #:________________________

Physician Office Name: ____

To be completed by parent:

I request and give permission for my child to carry and self-administer the medication(s) and/or procedure(s), as indicated in the physician's orders during the school day, at school-sponsored activities or while in transit to or from school. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, procedure equipment and supplies for their life-threatening health condition. Adult supervision will not be provided by the school. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding the school harmless against any injury or claims that arise as a result of the student's self-management of life-threatening condition. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication(s) and/or procedure(s). We/I are aware the privilege of self-administration of medication(s)/procedure(s) can be withdrawn if abused by the student. The school reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

____

Telephone **Printed Parent/Guardian Name** **Signature** **Date**

To be completed by student at school:

- ❑ I will keep my medication, supplies & equipment with me at school.
- ❑ I will use only as prescribed by my healthcare provider.
- ❑ I will not allow any other person to use my medication(s) or procedure equipment
- ❑ I will notify a school staff member if I am having more difficulty than usual with my health condition.

____

Telephone **Printed Student Name** **Signature** **Date**