ALLERGY/ANAPHYLAXIS PLAN FOR SCHOOL

April 2022

Dear Parents/Guardians,

If you and your student's medical provider believe your **high school or middle school** student is competent in recognizing his/her severe allergy symptoms and in the use of an Epi-pen, please provide the **"Medication Authorization and Contract to Self-Carry/Self-Administer Emergency Medication for Asthma and/or Anaphylaxis"** (attached). This will allow your student to manage, carry and administer his/her epi pen while at school. This form needs to be signed by a medical provider, a parent and the student.

It is strongly recommended that a back-up Epi-pen be available in the health office for students with a self-carry contract on file.

OR

If your student is an **elementary student OR a secondary student who is not able to manage his/her allergies and administer an epi-pen,** your student's epi-pen will need to be kept in the health office. Please provide the "**Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders".** This will allow staff to intervene during an allergic reaction and administer the epi-pen or any other medications that may be prescribed by a medical provider on this form. The form needs to be signed by a medical provider and a parent.

Please submit all forms to your school health office before the start of school. These forms need to be renewed yearly.

Please feel free to reach out for questions or to provide any other pertinent information about your child's allergy care to the Health Technician at your student's school or to the Elizabeth School District Nurse (303-646-6730).

Sincerely,

Lori Clark RN/BSN Elizabeth School District Nurse

MEDICATION AUTHORIZATION AND CONTRACT TO SELF-CARRY/SELF-ADMINISTER EMERGENCY MEDICATION FOR ASTHMA AND/OR ANAPHYLAXIS
20____ - 20____

Student Name: _____ DOB: _____ School: _____

FOR MEDICAL PROVIDER

Medication: _____ Dose:_____ Route: _____

Time/Frequency: _____ Purpose: _____

Possible Side Effects: _____

Through my consultation with the above-named student's parent(s)/guardian(s), as well as my own assessment of this student, I have determined that they are able to identify their correct medication, demonstrate correct self-administration of the above listed medication, and has knowledge of the required dosage and timing/frequency of use of the medication. The Student has been instructed in the purpose, appropriate method, and frequency of use of the medication and is capable of self-administering the medication. A new form must be completed for all medication changes.

Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

FOR PARENT(S)/GUARDIAN(S)

The Parent(s)/guardian(s) agree(s) to:
• Assure that my/our child, the above referenced Student, will carry their Medication as prescribed, and that the device containing the medication and provided to the above referenced school is appropriately labeled by a pharmacist or healthcare provider and contains medication that has not expired;
• Review the medical provider's order(s)/instruction(s) for the medication on a regular basis; and
• Provide additional medication to the health office for the above referenced school for emergencies at their discretion.

It is understood that the Medication will be self-administered solely at the request of, and as an accommodation to, the undersigned parent(s)/guardian(s). In return for the authorization for my/our child to possess and self-administer medication at school, the undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my/our child or I/we sustain from my/our child's possession and self-administration of medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Phone Number: _____

FOR STUDENT

The Student agrees to:
• Be responsible for possessing and self-administering their medication at school and school-sponsored events and use it in a responsible manner as instructed by the above referenced medical provider;
• Notify a staff member if they need assistance or if they have used an emergency medication (e.g. epinephrine, inhaler, etc.);
• Not allow any other student to administer their medication to themselves and understand that if they do, they will be appropriately disciplined in accordance with the Elizabeth School District's Student Code and Discipline; and
• Understand that failure to comply with this contract and applicable school board policy will result in the loss of privilege to possess and self-administer this medication.

Student Signature: _____ Date: _____

FOR DISTRICT NURSE

The District Nurse agrees to:
• Will meet with the student to verify the student's technique in self-administering the Medication and to check for understanding of the medical provider's order(s)/instruction(s);
• Notify appropriate school staff of student's condition and student's authorization to possess and self-administer their Medication; and
• Maintain appropriate records associated with the student's possession and self-administration of the Medication.

District Nurse Signature: _____ Date: _____

This document is for students who are self-carrying Medication to address their health concern(s) and is in effect for the current school year unless revoked by an authorized medical provider or if the Student fails to meet contingencies cited below.

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

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

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG: Short of breath, wheeze, repetitive cough
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Swelling of the tongue and/or lips
HEART: Pale, blue, faint, weak pulse, dizzy
SKIN: Many hives over body, widespread redness
GUT: Vomiting or diarrhea (if severe or combined with other symptoms
OTHER: Feeling something bad is about to happen, Confusion, agitation

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
   - ☐ Ask for ambulance with epinephrine
   - ☐ Tell EMS when epinephrine was given
3. Stay with child and
   - ☐ Call parent/guardian and school nurse
   - ☐ If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - ☐ Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

1. Stay with child and
   - ☐ Alert parent and school nurse
   - ☐ Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____