



LIFE-THREATENING ALLERGY PACKET

Dear Parent/Guardian,

You indicated that your child may have a life-threatening allergy to a food, insect or other allergen that may require the use of Epinephrine (EpiPen) or/and Antihistamine (such as Benadryl). In order to ensure the safety of your child while attending school, we ask that you and your child's physician please complete all applicable forms in the following packet. In addition to completing the paperwork, we would advise you to obtain additional doses of the required medication to have at school in the event of exposure to allergens.

Please bring your child's labeled medication to the health office by the first day of school, along with the completed packet. The school nurse will want to meet with you to review the types of allergens and symptoms your child experiences when exposed. Please call the school nurse at your earliest convenience to discuss your child's health considerations for this school year.

Thank you

PAQUETE DE INFORMACIÓN PARA ALERGIA QUE AMENAZA LA VIDA

Estimado Padre / Tutor,

Usted Indicó que su hijo puede tener una alergia potencialmente mortal a un alimento, insecto u otro alérgeno que puede requerir el uso de epinefrina (EpiPen) y / o antihistamínico (como Benadryl). Para garantizar la seguridad de su hijo mientras asiste a la escuela, le pedimos que usted y el médico de su hijo completen todos los formularios correspondientes en el siguiente paquete. Además de completar el papeleo, le recomendamos que obtenga dosis adicionales de los medicamentos requeridos para tener en la escuela en caso de exposición a alergenos.

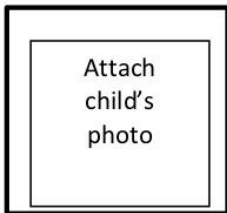
Lleve el medicamento etiquetado de su hijo a la oficina de salud de su escuela antes del primer día de clases, junto con el paquete completo. La enfermera de la escuela querrá reunirse con usted para revisar los tipos de alérgenos y síntomas que su hijo experimenta cuando está expuesto. Llame a la enfermera de la escuela tan pronto como sea posible para discutir las consideraciones de salud de su hijo para este año escolar.

Gracias

Allergy and Anaphylaxis Emergency Plan

Name:	Date of Birth:	Weight:
Date of Plan:	Age:	lbs / kg
ALLERGIES:		

Child has asthma: yes / no (if yes, higher chance of a severe reaction)
 Child has had anaphylaxis: yes / no (if yes, higher chance of a severe reaction)
 Child may carry medicine: yes / no
 Child may give him/herself medicine: yes / no (if child refuses, an adult must give medicine)



The "Always-Epinephrine" Option: If checked, **give epinephrine** immediately, if the child has ANY symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always present.)

****IF IN DOUBT, GIVE EPINEPHRINE!** ANAPHYLAXIS is a potentially life-threatening, severe allergic reaction

<p>For SEVERE Allergy or Anaphylaxis</p> <p>What to look for: If child has ANY of these symptoms after eating a food or having a sting, give epinephrine</p> <ul style="list-style-type: none"> ➢ <u>Breathing</u>: trouble breathing, wheeze, cough ➢ <u>Throat</u>: tight or hoarse throat, trouble swallowing or speaking ➢ <u>Brain</u>: confusion, agitation, dizziness, fainting, unresponsiveness ➢ <u>Gut</u>: severe stomach pain, vomiting, diarrhea ➢ <u>Mouth</u>: swelling of lips or tongue that affects breathing ➢ <u>Skin</u>: face color is pale or blue, many hives or redness over body 	<p style="text-align: center;"></p> <p>Give EPINEPHRINE!</p> <p>What to do:</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note the time. 2. Call 911 <ul style="list-style-type: none"> • Ask for ambulance with epinephrine • Tell rescue squad when epinephrine was given 3. Stay with child and: <ul style="list-style-type: none"> • Call parents • Give a second dose of epinephrine if symptoms worsen or do not get better in 5 minutes • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on their side 4. Give other medicine (e.g. antihistamine, inhaler) if prescribed. Do not use other medicine in place of epinephrine.
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<p>For MILD Allergic Reaction</p> <p>What to look for: If child has mild symptoms, or no symptoms but a sting or ingestion of the food is suspected, give antihistamine and monitor the child. Mild symptoms may include:</p> <ul style="list-style-type: none"> ➢ <u>Skin</u>: a few hives, mild rash, mild swelling, OR ➢ <u>Mouth/nose/eyes</u>: itching, rubbing, sneezing, OR ➢ <u>Gut</u>: mild stomach pain, nausea or discomfort <p>Note: if the child has more than one mild symptom area affected, give epinephrine</p>	<p style="text-align: center;"></p> <p>Give Antihistamine and Monitor the Child</p> <p>What to do:</p> <ol style="list-style-type: none"> 1. Give antihistamine if prescribed 2. If in doubt, give epinephrine 3. Call parents 4. Watch child closely for 4 hours 5. If symptoms worsen, give epinephrine (See "For SEVERE Allergy and Anaphylaxis")
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Medicine/Doses

Epinephrine (intramuscular in thigh): 0.15 mg 0.30 mg
 Antihistamine (by mouth): Diphenhydramine _____ mg (_____ ml) Other _____: _____ mg (_____ ml)
 Other medications: Albuterol 2-4 puffs other: _____

PROVIDER Signature	Date	Name (printed)	Phone	FAX
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PARENT/GUARDIAN Signature	Date	Name (printed)	Phone	
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I authorize the school to follow Plan and contact the Health Care Provider, and release the school district and personnel from civil liability

Reviewed by school nurse: _____ Date: _____

Allergy and Anaphylaxis Emergency Plan

Child's name: _____ Date of Plan: _____

Additional Instructions:

Contacts

Doctor name (print): _____
Office Address: _____

Office Phone: (____) _____ - _____
Office Fax: (____) _____ - _____

Parent/Guardian name (print): _____ Phone: _____

Parent/Guardian name (print) : _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Reviewed by school nurse: _____ Date: _____

FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT



PARENT/GUARDIAN STATEMENT

Board Policy 5141.21 Administering Medication and Monitoring Health Conditions

Any pupil who requires medication or prescribed health services, may be assisted by a school nurse or other designated school district personnel if the district receives this PARENT/GUARDIAN STATEMENT and a HEALTH CARE PROVIDER STATEMENT. This authorization is valid only for the current school year.

The HEALTH CARE PROVIDER STATEMENT must be completed by an individual licensed by the State of California to prescribe or order medication including, but not limited to, a physician or physician assistant. The statement should include the medication name, route of administration, amount (dose), time and reason by which such medication is to be taken, as well as side effects.

I, the parent/guardian, agree to provide a new PARENT/GUARDIAN STATEMENT and HEALTH CARE PROVIDER STATEMENT if there is a change in the prescribed medication or health service.

I, the parent/guardian, acknowledge that medication and health service should be administered at home whenever possible. Medication and health services should only be administered at school when it is necessary for continued attendance or an emergency. Medication/health services that are administered once, twice or three times daily should be administered at home before and after school when possible.

I, the parent/guardian, agree to provide medication in original containers which are clearly marked with my child's name, name of the medication and expiration date. Medication bottles at school should not be "refilled" from another bottle. Medication must be brought to school by a parent/guardian unless my child has a self-carry agreement between the physician, parent, student and school. If my child has a self-carry agreement, I consent to allow my child to self-administer/carry medication and supplies. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of providing self-care.

I, the parent/guardian, acknowledge that my child may receive medication or assistance from a school nurse or other district designee according to Education Code Section 49423. I recognize that I am responsible for providing all necessary supplies and equipment. This is a service or accommodation which the school is not legally required to perform. I agree to waive and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication, or health service, in accordance with this request.

I, the parent/guardian, grant permission for an authorized district representative to communicate directly with my child's authorized health care provider and pharmacist, as may be necessary, regarding the health care provider's written statement or any other questions that may arise with regard to the prescribed medication(s) or health service(s).

I, the parent/guardian, understand that I may terminate this authorization for medication administration or other prescribed health services for my child at any time. I request that a school nurse or other district designee administer the medication/services as directed by the physician, for my child:

Student's Name

Parent / Guardian Signature

Date

Home / Cell Phone Number

Work Phone Number

Home / Cell Phone Number

Work Phone Number



DECLARACIÓN DEL PADRE/TUTOR

Póliza de la Directiva 5141.21 Administración de Medicamentos y Supervisión de Condiciones de Salud

Cualquier alumno(a) que requiera medicamento o servicios de salud prescritos puede ser asistido por la enfermera de la escuela o cualquier otro miembro del personal del distrito asignado si el distrito recibe esta DECLARACIÓN DEL PADRE o TUTOR y una DECLARACIÓN DEL PROVEEDOR DEL CUIDADO DE SALUD. Esta autorización es únicamente válida para el año escolar en curso.

Un individuo con licencia del Estado de California para recetar y ordenar medicamentos incluyendo pero no limitado a un médico o asistente médico debe llenar la DECLARACIÓN DEL PROVEEDOR DEL CUIDADO DE SALUD. La declaración debe incluir el nombre del medicamento, vía de administración del mismo, cantidad (dosis), la hora y la razón por la cual tal medicamento debe tomarse, así como los efectos secundarios.

Yo, el padre/tutor, acepto proporcionar, una nueva DECLARACIÓN DEL PADRE/TUTOR y DECLARACIÓN DEL PROVEEDOR DEL CUIDADO DE SALUD si hay un cambio en el medicamento recetado o el servicio de salud.

Yo, el padre/tutor, estoy consciente que el medicamento y servicio de salud debe administrarse en el hogar cuando sea posible. Los medicamentos y servicios de salud únicamente deben administrarse en la escuela cuando sea necesario para la asistencia continua o una emergencia. Los medicamentos y servicios de salud que se tienen que administrar una, dos o tres veces al día deben administrarse en casa antes y después de clases cuando sea posible.

Yo, el padre/tutor acepto proporcionar el medicamento en su frasco original el cual está claramente etiquetado con el nombre de mi hijo(a), nombre del medicamento y día de expiración. Los frascos de medicamento que se encuentran en la escuela no se deben rellenar con medicamento de otros frascos. El medicamento debe ser llevado a la escuela por el padre/tutor a menos que mi hijo(a) tenga un acuerdo entre el médico, padre, estudiante y escuela de llevar el medicamento por sí mismo(a). Si mi hijo(a) tiene un acuerdo para llevar su propio medicamento, le autorizo a llevar su medicamento y artículos, y que se lo administre él/ella mismo(a). Yo libero al distrito y el personal escolar de cualquier responsabilidad civil si mi hijo(a) sufre una reacción adversa como resultado de proporcionarse cuidado de salud a sí mismo(a).

Yo, el padre/tutor estoy consciente de que mi hijo(a) puede recibir medicamento o asistencia de la enfermera de la escuela u otra persona asignada de acuerdo con el Código de Educación Sección 49423. Yo acepto que soy responsable de proporcionar todos los artículos necesarios y equipo. Este es un servicio o adaptación que la escuela no está legalmente obligada a llevar a cabo. Acepto renunciar y eximir al distrito, sus funcionarios, empleados o agentes de toda responsabilidad demanda o reclamo de cualquier naturaleza o clase que pueda surgir como resultado de la administración del medicamento o servicio de salud, de acuerdo con esta petición.

Yo, el padre/tutor otorgo mi permiso para que un representante autorizado del distrito se comunique directamente con el proveedor de cuidado de salud y el farmacéutico autorizados de acuerdo como sea necesario con respecto a la declaración por escrito del proveedor de cuidado de salud o cualquier otra cuestión que surja con respecto al/los medicamento(s) prescrito(s) o servicios de salud.

Yo, el padre/tutor, entiendo que puedo rescindir esta autorización para la administración de medicamentos u otros servicios de salud recetados para mi hijo(a) en cualquier momento. Solicito que la enfermera de la escuela u otra persona designada por el distrito administre el/los medicamento(s)/servicio(s) como lo indica el médico para mi hijo(a).

Nombre del Estudiante

Firma del Padre o Tutor Legal

Fecha

Número de Teléfono del Hogar o Celular

Número de Teléfono del Trabajo



Authorization for use or Disclosure of Health Information to School Districts

Completion of this document authorized the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Use and Disclosure Information:

Patient/Student Name: _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and / or health care providers):

1) _____ 2) _____
to provide health information from the above-named child's medical record to and from:

_____ Address / City and State / Zip Code
School District to Which Disclosure is made

_____ Area Code and Telephone Number
Contact Person at School District

The disclosure of health information is required for the following purpose:

Requested health information shall be limited to the following: _____
All health information or
Disease specific information as described:

Duration: This authorization shall become effective immediately and shall remain in effect until _____
or for one year from the date of signature, if no date entered.

Restrictions: Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

Your Rights: I understand that I have the following rights with respect to this Authorization: **I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies / persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.**

Re-Disclosure: I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of the Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

Approval:

_____ Signature _____ Date _____
Printed Name

_____ Area Code and Telephone Number
Relationship to Patient / Student