SVUSD Emergency Care Plan for Treatment of Allergic Reaction - Epinephrine Autoinjector Administration by School Health Professionals and Trained Personnel

Student: _____ DOB: _____ Grade: _____

Allergy:_____ Date of Last Reaction: _____

Type & Severity of Reaction: _____ Has an Epi-Pen Ever Been Used? Yes No

Are ANY of these severe signs and symptoms present?	**OR is there a COMBINATION of MILD symptoms from DIFFERENT body areas?**
LUNG: Short of breath, wheezing, repetitive cough HEART: Pale, blue, faint, weak pulse, dizziness THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Significant swelling (tongue and/or lips) SKIN: Many hives over body , widespread redness Gut: Repetitive vomiting, severe diarrhea Other: Feeling of impending doom, anxiety, confusion	SKIN: A few hives, mild itch GUT: Mild nausea or discomfort NOSE: Itchy or runny nose, sneezing MOUTH: Itchy mouth **If YES to either criteria, quickly follow the protocol below:** If No, see MILD SYPMTOMS section on reverse.

DO NOT DELAY TREATING ANAPHYLAXIS. When in doubt, administer epinephrine. *Treating anaphylaxis in the first few minutes can save a life. Not all anaphylaxis has skin symptoms.*

1. **IMMEDIATELY ADMINISTER EPINEPHRINE AUTOINJECTOR PER STUDENT ORDER:**
   - ☐ 0.15 mg - body weight less than 66 pounds
   - ☐ 0.30 mg - body weight 66 pounds or more
2. Inject into middle outer side of upper leg, note time and site of injection
3. Stay with student and monitor closely
4. Designate a person to call Emergency Medical System (911) and request ambulance with epinephrine
5. Designate a person to notify school administration, student's emergency contact(s) & the District Nurse.

↓

6. Stay with and observe student until EMS (ambulance) arrives.
   - Maintain airway, monitor circulation, start CPR as necessary.
   - Do not have the student rise to an upright position.
   - Consider lying on the back with legs elevated, but alternative positioning is needed for vomiting (side lying, head to side) or difficulty breathing (sitting).
   - Observe for changes until EMS arrives.

☐ **IF NO IMPROVEMENT OR IF SYMPTOMS WORSEN AFTER 5 MINUTES, ADMINISTER A SECOND EPINEPHRINE DOSE**
   - Provide EMS with identifying information, observed signs and symptoms, time epinephrine administered, used epinephrine autoinjector to take with to the hospital

7. **Transport to the Emergency Department via EMS even if symptoms seem to get better.**

SVUSD - Protocol Notes - For an emergency, follow the directions on the reverse side
Epinephrine Autoinjector Administration by School Health Professionals and Trained Personnel

DO NOT DELAY TREATING ANAPHYLAXIS. *Treating anaphylaxis in the first few minutes can save a life.*

- **MILD SYMPTOMS**: Whether or not there was exposure to a known trigger, accompany student to health office to monitor closely and assess. Do not delay administration of epinephrine if symptoms progress.
  - Do not leave the student. Monitor for 30 minutes. Mild symptoms can quickly become severe.
  - **If symptoms become severe, administer epinephrine per protocol on reverse.**

☐ INHALER: _____

☐ ANTIHISTAMINE: _____

Transporting to the hospital:

- Students should always be transported to the hospital following administration of epinephrine and accompanied by parent or school representative.
- They are at risk for a secondary or biphasic reaction which may require immediate treatment (as many as 1/3 of children will experience a secondary reaction).[3]

After an emergency event:

- Make sure parents/guardians are notified to follow up with private physician. Follow up with family - evaluate plan.
- In the case of the student with known history, discuss how exposure occurred and if new allergen avoidance measures are needed. For students with no previous history of anaphylaxis, consider developing an IHP in collaboration with the PCP for possible future occurrences.
- Complete documentation per district policy.
- Make sure replacement epinephrine autoinjector is obtained.
- Review response and emergency communication, update as needed to improve outcomes.

"Parent/Guardian And Authorized Health Care Provider Request For Medication" Form MUST be attached for each medication

PARENT'S AUTHORIZATION

Parent Signature: _____ Date: _____

District Nurse: _____ Date:_____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES

HEALTH HISTORY INFORMATION

Student: _____ **ID#:** _____ **Effective:** _____

DOB **School:** **Teacher:** **Gr:**

The above student has the following condition(s***):***

1. _____
2. _____
3. _____

Please provide us with the following information so that I may have a better understanding of your child's needs while at school

1. Is your child under the care of a physician for the above condition(s) Yes ☐ No ☐
2. Has your child had a problem with this condition in the last year? Yes ☐ No ☐

➢ ***Physician's name*** _____ ***Phone***: _____

3. Should your child's activities at school be restricted in any way? (Please explain) Yes ☐ No ☐

_____

_____

4. Does your child take medication(s) regularly? Reason? _____

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

5. What action do you want the school to take when your child is sent to the Health Office for a problem?

_____

_____

_____

6. Please list any other information that might be helpful in caring for your child. _____

_____

_____

_____

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION: I authorize the school nurse to communicate with the physician when necessary. I hereby give my permission for exchange of confidential information contained in the record of my child.

_____ _____

Parent Signature: **Date**

_____ _____

Reviewed by Health Services **Date**

Saddleback Valley Unified School District
Medication Authorization Form

E 5141.21

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____ Birthdate: _____

School:_____ Teachers Name:_____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature:_____ Date:_____

Telephone: (Work)_____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication:_____ Dose:_____ Route:_____ Time: _____

If PRN: Amount of time between doses_____ Maximum number of doses_____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

By signing below, I verify the information is correct and medication may be administered by a trained, unlicensed professional.

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone_____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication:_____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:
Reviewed by:_____ Date: _____

This request is valid for a maximum of one year.

Revised 8-20-2020 es

Saddleback Valley Unified School District
Medication Authorization Form

E 5141.21

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

***Name of Student**:* _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

Revised 8-20-2020 es