STUDENT HEALTH HISTORY - ALLERGY

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Doctor: _____ Doctor's Number: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Allergy/Allergies: _____

Year diagnosed with allergy: _____ Date of most recent reaction: _____

Has your child been prescribed emergency epinephrine (Epi-Pen)? ___Yes ___ No

- If yes, has it been necessary for your child to receive the emergency injection? ___ Yes ___ No
- When? _____ How many times has an emergency injection been needed? _____

Signs of an allergic reaction in my child may include: (*please check all boxes below that may apply.*)

- ☐ **Mouth-** itching and swelling of lips, tongue or mouth
- ☐ **Throat-** itching and/or tightness; hoarseness, hacking cough
- ☐ **Skin-** hives, itchy rash, and/or swelling of the face or extremities, pale, clammy
- ☐ **GI-** nausea, abdominal cramps, vomiting, and/or diarrhea
- ☐ **Lungs-** shortness of breath, repetitive cough, and/or wheezing
- ☐ **Heart-** thready, weak pulse, loss of consciousness, pale
- ☐ **Other** _____

Does your child take any allergy medications at <u>home?</u> ___ Yes ___ No If yes, please list:

Medication	Dose	How often
1.		
2.		

*Please complete and sign reverse

Does your child require emergency medications be kept at school in the event of an allergic reaction?
___ Yes __ No

If yes, list the emergency medications below:

Medication Authorization forms must be completed and signed by parents and the prescribing physician and be on file at the school before any medications may be administered. Parent must bring medications to school

Medication	Dose	Describe When to Use
1.		
2.		

Do you request that your child sit at a peanut or other allergen-free table? ___ Yes ___ No
Please contact the school nurse to discuss other requested accommodations.

I understand that my child's Emergency Action Plan will be shared with appropriate school staff that have a need to know about the health condition. I further understand that the school is not responsible for damage or loss of equipment utilized in providing medically prescribed treatments or procedures.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information provided on this Health History form.

Parent/Guardian: _____ _____
Signature Date

Reviewed by: _____ _____
School Nurse Date

****

FOR SCHOOL NURSE USE ONLY

Notes: _____

_____

_____

Student Name_____ # _____

First Baptist Academy
Medication Authorization Form

Student's Name: _____ Sex: M ☐ F ☐ Date of Birth: _____

Teacher: _____ Grade: _____

Allergies: _____

MEDICATION INFORMATION

Medical Condition for which medication will be required for student in school: _____

Name of Medication: Prescription _____ Over-the-Counter _____

Route to administer (*please check one)* ☐ Oral (BY MOUTH) ☐ Topical (ON THE SKIN) ☐ Subcutaneous (INJECTED) ☐ Inhaled (BREATHED) ☐ IM Other _____

Dosage: _____ Frequency: _____ Time of Day: (ex.11:00 AM) _____

Is this a new medication? ☐ Yes ☐ No If yes, the first dose must be administered at home.

Special Instructions: _____

Prescription medications require healthcare provider signature below:
Physician's orders are required for <u>all prescription medications given at school</u>

Physician's Name (Print): _____ Phone Number: _____

Physician's Signature: _____ Date: _____ Fax Number: _____

☐ I have prescribed the student to ***self-carry*** MDI, pancreatic enzymes, EPI-PEN, or other life saving medications described on this page.

PARENT/GUARDIAN AUTHORIZATION

1. I give permission for my child's doctor to be contacted for information regarding the administration of the medication listed on this form.
2. I authorize the above medication to be administered as described or prescribed during school or after-school programs operated by Collier County Public Schools.
3. I understand that medication not picked up by the last day of school will be discarded.
4. I understand that medication may not be administered if either the "discard after date" or the manufacturer's expiration date has passed.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

Home phone: _____ Business phone: _____ Emergency phone number: _____

FOR SCHOOL NURSE USE ONLY

☐ Physician's Verbal Order Obtained: Date: ___ Time: _____ Received From: _____

Content of physician's verbal order obtained: _____

Reviewed by: _____ Date: _____

School Nurse

Please see reverse side of this document for Medication Authorization Information

First Baptist Academy Medication Authorization Form

Dear Parent/Legal Guardian:

If your child requires medication(s) during the school day, FBA requires that you provide authorization for all medications to be given. An authorization for prescription medication must also be completed and signed by a physician.

- The Medication Authorization Form on the reverse side of this document must be entirely completed and accompany prescribed or over-the-counter medications to be given to your child in school. The form must be signed by a parent/legal guardian. The prescribing healthcare-provider must also complete and sign the form for any **prescription** medications to be given.

- A parent/legal guardian or an authorized adult must deliver medications to the school. At the time of delivery, the quantity of each medication will be verified by the school nurse. **Please avoid sending medications to school with your child**.

- Medications given only one time per day or medications that can be given before or after school are not administered at school.

- Prescription medications must be received at school in a container with the **original**, unaltered prescription label attached. The l**abel must be written in English and** display all information required by law, including, but not limited to: date of prescription, “discard after date,” student's name, medication name, dosage, time to be administered, and the prescribing healthcare-provider's name.

- Medication may not be administered at school if either the “discard after date” **or** the manufacturer’s expiration date has passed.

- Over-the-counter (OTC) medications must be in the original sealed (unopened) store-issued container. Please label the container with your child's full name and birth date. OTC medications will only be given according to directions on the label. If a parent/ guardian requests dosages that do not appear on the non-prescription medication label, orders stating the reason for the administration variation must be obtained from the healthcare-provider by the parent/guardian and will be considered by a school nurse before administration may occur. **Based on the school nurse’s assessment, a parent may be required to obtain a physician’s authorization for increased and/ or daily administration of a non-prescription medication.**

- If your child is authorized to self-carry and use life saving medications as prescribed by his/her healthcare-provider, the child must demonstrate competency in self-administration/self-treatment and a “Contract for Self-Carried Medication” must also be completed and signed by the parent and school nurse. **Medication with current prescription label must be signed-in to school clinic.**

- **This Medication Authorization form is only valid for 1 school year. A new form must be completed for each school year.**

Please see reverse side of this document for Medication Authorization

FOOD/INSECT & EMERGENCY ALLERGY ACTION PLAN and MEDICATION AUTHORIZATION

School District / School Name _____ **Date** _____ **School Year** _____

www.foodallergy.org

Student Name	Date of Birth	Student #
*Health Care Provider Name/Title	Provider's Office Phone / FAX #	
Parent/Guardian	Parent's Phone #s	
Emergency Contact	Contact Phone #s	
Student's weight: _____ **lbs.**	**Asthma:** ☐ **YES (higher risk for a severe reaction)** ☐ **No**	

Epinephrine injector is stored in:

☐ With Student
☐ Classroom
☐ Health Office
☐ _____

Allergy to:

Give epinephrine immediately:

[ ] for ANY symptoms if allergen was likely eaten.

[ ] If allergen was definitely eaten, even if no symptoms are noticed.

TREATMENT PLAN

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:

LUNG: Short of breath, wheezing, repetitive cough
HEART: Dizzy, faint, confused, pale, blue, weak pulse
THROAT: Tight, hoarse, trouble breathing/swallowing, drooling
MOUTH: Swelling of tongue, lips
SKIN: Many hives over body, widespread redness over body
GUT: Nausea, repetitive vomiting, severe diarrhea, cramping
Other: Feeling something bad is about to happen, anxiety, Confusion

OR A combination of mild symptoms from different body areas

FOLLOW THIS PROTOCOL:

1. **INJECT EPINEPHRINE IMMEDIATELY!** (Note time)
2. **Call 911.** Request ambulance with epinephrine. Don't hang up & don't leave student
   - Give additional medications as ordered [Antihistamine (if ordered below)] [Inhaler (Albuterol) if student has asthma]
   - Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side
   - Notify School Nurse and Parent/Guardian
   - Notify Prescribing Provider / PCP
   - When indicated, assist student to rise slowly
   - Student must be transported to ER

MILD ALLERGY SYMPTOMS:

MOUTH: Itchy mouth, lips, tongue and/or throat
SKIN: A few hives, itchy skin
NOSE: Itchy/runny nose, sneezing
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE (as ordered below)
2. Stay with student; alert school nurse & parent/guardian
3. Watch student closely for changes
   - If symptoms worsen, **GIVE EPINEPHRINE**
   - For mild symptoms from more than one body area - **GIVE EPINEPRHINE** (see above).

➢ **THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!**

MEDICATION ORDER

Epinephrine	☐ **Epinephrine (0.15mg)** inject intramuscularly Epi Pen Auvi Q Adrenaclick	☐ **Epinephrine (0.3mg)** inject intramuscularly Epi Pen Auvi Q Adrenaclick	
	A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.		
Antihistamine Do not depend on antihistamines or inhalers. ***When in doubt, give epinephrine and call 911.***	☐ Benadryl/Diphenhydramine Dose: _____mg. Route: PO	☐Other _____ Dose: _____mg Route:	Note: If School Nurse is not available, the above treatment plan may be provided by trained school personnel for any anaphylaxis symptoms.

MUST BE COMPLETED BY PARENT AND AUTHORIZED HEALTH CARE PROVIDER

AUTHORIZATION

***Prescriber's Signature:** _____ **Date:** _____

Printed Name: _____ **Phone:** _____

Student is able to carry and self-administer his/her medication at school ☐ Yes ☐ No

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ **Date:** _____

I confirm my child is capable to carry and administer above medication ☐ Yes ☐ No

School Nurse:

I have reviewed this order and completed the Allergy Emergency Care Plan and have trained school personnel.

_____
Signature / Date

Medication Expires on:

_____