Parent	☐
Physician	☐

Bullitt County Public Schools

1040 Highway 44 East
Shepherdsville, Kentucky 40165

Phone: 502-869-8000
Fax: 502-543-3608
www.bullittschools.org

ALLERGY REACTION PARENT PACKET

Dear Parent and/or Guardian;

I am sending home forms that will be used by school personnel in caring for your child's medical needs during the 2020-2021 school year. Attached is an allergy reaction medical action plan and medication permission form that will need to be completed **in full** with physician signature **prior** to bringing the medication to school. If your child will be carrying epinephrine for self-administration please see below.

Students are allowed to carry their medications if the following conditions are met:

- **Physician/Parent Authorization Form is complete and on file at school;**
- **Medication Permission Form is complete and on file at school;**
- **Primary Care Provider has instructed student in self-administration of the student's prescribed medication to treat Anaphylaxis;**
- **Medical forms must be updated each school year**

When Students self-administer medication, the school staff will NOT be responsible for monitoring frequency of use, expiration date, or amount of medication available for use. It is recommended that an additional dose be kept in the office.

As our policy 09.2241 states, "All prescription medication, original or refill, shall be brought to school in the most current pharmacy labeled container which includes the student's name, date, medication, dosage, strength, and directions for use including frequency, duration, and mode of administration, prescriber's name, pharmacy name, address and phone number. Labels that have been altered in any way shall not be accepted."

.

If your child will need an asthma packet for next school year please contact the school or download from the Bullitt County website. (student services-health services-documents)

Please remember that the schools are not to administer any medication and your child is not to carry any medication without proper paperwork and signatures on file. We appreciate your understanding and cooperation with this policy.

Sincerely,

Lesa A. Howell, RN

Lesa A. Howell, R.N. B.S.N.
District Health Coordinator
Bullitt County Public School

Bullitt County Public Schools Health Service
Primary Care Provider Authorization: Anaphylaxis

Student: ______________________________ Date of Birth: ______________ School Year ______________

Allergy to:

☐ Peanuts ☐ Milk ☐ Insect Stings (list) ______________________________

☐ Tree Nuts ☐ Medication ☐ All Dairy

☐ Shellfish ☐ Animals ☐ Eggs (visible only?) ☐ Yes ☐ No

☐ Latex ☐ Fish ☐ Other ______________________________

Asthma: ☐ **Yes**** ☐ **No** **History of Anaphylaxis reaction:** ☐ **Yes**** ☐ **No** ****High risk for severe reaction**

Student is extremely reactive to: ______________________________

☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if there are no symptoms

☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms

SEVERE SYMPTOMS

For **ANY** of the following:

Lung Shortness of breath, wheezing, repetitive cough	**HEART** Pale or bluish skin, faintness, weak pulse, dizziness
SKIN Many hives over body, widespread, redness	**GUT** Repetitive vomiting, severe diarrhea
Mouth Significant swelling of the tongue or lips	**Throat** Tight or hoarse throat, trouble breathing or swallowing
OTHER Feeling something bad is about to happen, anxiety, confusion	**OR A COMBINATION of symptoms from different body areas.**

NOTE:DO NOT depend on antihistamines or inhalers to treat a severe reaction. USE EPINEPHERINE

1. INJECT EPINEPHERINE IMMEDIATELY.
2. CALL 911. Request ambulance with epinephrine.
   *Consider giving additional medications (following or with the epinephrine):
   *Antihistamine
   *Inhaler
   Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lay on their side.
3. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the first dose.
4. Alert emergency contacts.
5. Transport student to ER even if symptoms resolve.

MILD SYMPTOMS

For **2** or **MORE** mild symptoms – GIVE EPIPINEPHERINE

NOSE Itchy, Runny nose, or sneezing	**MOUTH** Itchy mouth
SKIN A few hives, mild itch	**GUT** Mild nausea, discomfort

For only 1 mild symptom-

1. Give ANTIHISTIMES, IF ORDERED BY PHYSICIAN (medication permission form on page 3)
2. Stay with the student; alert emergency contacts
3. Watch student closely for changes.

If symptoms worsen, GIVE EPINEPHERINE.

Does this student need to be in a peanut free class room? ☐ **Yes** ☐ **No**

Peanut free table for meals? ☐ **Yes** ☐ **No**

Physician Signature: ______________________________ Address: ______________________________

Physician Printed Name: ______________________________ Phone: (___) ____-______________ Fax: (___) ____-______________

I/WE give permission for ______________________________ to receive the prescribed medications listed on the "Medication Permission
Student's Name
Form" for any medications given at school according to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed. I/We acknowledge that the school district shall incur no liability and I/We shall indemnify and hold harmless the school district and its employees against any claims relating to the self-administration or administration by school personnel of medications used to treat anaphylaxis.

✕**Parent/Guardian Signature** ______________________________ **Date** ______________ **Phone**______________

Permission Forms for Medication

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Student's Name: ________________________ Grade: ________ Age: _______ Date of Birth: _____/_____/_____
School: ____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of Medication: ____	**Name of Medication:** ____
Reason: ________________ **Stop date**: ___/___/___ or End of School Year	**Reason:** ________________ **Stop date**: ___/___/___ or End of School Year
Time to be given: __________ **Dose** __________**MG/ML/PUFFS/UNITS** **(please circle one)**	**Time to be given:** __________ **Dose** __________**MG/ML/PUFFS/UNITS** **(please circle one)**
Signs and symptoms of emergency administration: ____	Signs and symptoms of emergency administration: ____
Restriction and/or important side effects: _____________________________	Restriction and/or important side effects: _____________________________
* Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No	* Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No
SPECIFIC TO FIELD TRIPS ONLY: *(Please check 1 box)* ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time) ☐ * Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)** ☐ Student requires medication to be administered (School personnel will hold medication and administer)	***SPECIFIC TO FIELD TRIPS ONLY:*** *(Please check 1 box)* ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time) ☐ * Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)** ☐ Student requires medication to be administered (School personnel will hold medication and administer)

PROVIDER SIGNATURE FOR ALL MEDICATIONS

____ ___/___/___
Physician/Health Care Provider Signature Date

Physician Practice name: ____
Address: ____
Phone: (___) ________________________ Fax: (___) _____________________

***FOR SELF CARRYING/ SELF ADMINISTRATION ONLY**

______***(MD INITIALS)** The above-named student has been instructed on the care, storage, dosage, and use (up to/and including getting help of trained personnel if student feels they are unable to administer the medication safely/effectively in an emergency situation) of the above medication(s) and has sufficient knowledge and ability to self-carry / self-administer the medication(s) in the school setting and while on field trips.

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS

I give permission for ____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _______________________ *Signature:* ____ *Relationship:* _______________________________

Home Phone: _________________________ *Work Phone* _______________________________ *Emergency Phone* _______________________________

I/we reviewed the statement and authorization for completion. ***Administrator/designee*** ___________________________________ Date ___/___/___

Consent Form for Mutual Exchange of Information

Student's Name: ____Date: __________________________________

Date of Birth: _____________________________________ Social Security Number: XXX-XX-_____________________

Parent/Guardian: ____

Address: ____

I, the parent/guardian of the above-named student, hereby authorizes the mutual exchange of information including use and/or disclosure of protected health information and educational records between the Bullitt County Public School's District Health Coordinator and the physician, individual or organization listed below.

Physician, Individual, or Organization Name: ____

Address: ____Phone #: ___________________________

The information will be used or disclosed upon request for the following purposes:

- □ Developing a medical plan for the student at school.
- □ Assessing the need for a medical transfer.
- □ Assessing the need for the student to access the Home Hospital Program.
- □ Addressing issues related to the student missing school/excessive absences.

Please allow consultation and/or forward documents to Bullitt County Public Schools:

- □ Addressing medical needs related to treatment for the following condition or injury ______________________________________ on or about ________________________.
- □ Including medical records covering the period of time _________ to _________.
- □ Reviewing or requesting any and all progress notes, care plan notes, and/or discharge notes to assess student needs, covering the period of time ____________ to ____________.
- □ Other: ____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the named physician/practice/organization and the Bullitt County Public Schools. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that if my healthcare provider is asking to use/disclose my information, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: ____.

I certify that I have received a copy of this authorization. I further certify that I am the parent or legal guardian of the above-named student or that I am the student of majority age and have the authority to sign this release.

____ ____________________________ ___________________

Signature Relationship Date

34 CFR SEC 99.30 (Federal Family Educational Rights and Privacy Act of 1974) allows the release of certain records to third parties when:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. Written consent must: a. Specify the records to disclose. b. Purpose of disclosure. c. Identify whom disclosure made.
3. When disclosure is made: a. Parent or eligible student to receive a copy of records, if desired. b. Student to be provided a copy of the records disclosed, if parent requests.
4. Signed and dated written consent may include signature in electronic form if person is identified, authenticated and person's approval indicated.