ISSAQUAH SCHOOL DISTRICT 411

LIFE-THREATENING ALLERGY/504 PLAN

Student Name:	picture
DOB:	Teacher:
Grade:	School Year:
School:	

♦ SIGNS OF AN ALLERGIC REACTION ♦

• MOUTH	itching, tingling, or swelling of the lips, tongue or mouth
• THROAT	sense of tightness, itching in the throat, hoarseness, change in voice, throat clearing
• SKIN	hives, itchy rash, and/or swelling
• GUT	nausea, stomachache, abdominal cramps, vomiting, and/or diarrhea
• LUNG	shortness of breath, repetitive coughing, and/or wheezing
• HEART	fainting, dizziness, weak pulse, blueness, and/or pale skin
• GENERAL	anxiety, confusion, sudden fatigue, chills, and/or feeling that something bad is about to happen

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

Severe allergy to _____ Date of Last Reaction: _____

Asthma *Yes* ☐ **High Risk for severe reaction No ☐

♦ MEDICATION ORDERS ♦

Give: ☐ Epinephrine Auto-injector **(0.3mg)** ☐ Epinephrine Auto-injector **(0.15mg)**

☐ If symptoms persist after_____minutes; give second dose of Epinephrine Auto-injector if available.

Antihistamine_____Dosage _____ Route_____Time_____

Yes ☐ No ☐ Can this student responsibly **carry** the emergency medication in their backpack/purse?
Yes ☐ No ☐ Can this student responsibly **self-administer** the emergency medication?
Yes ☐ No ☐ Student demonstrated for the LHCP the skill necessary to self-administer the Epinephrine?

Licensed Health Care Professional authorizing administration of above medications:

Signature _____ Date _____

Print name _____Phone_____ Fax_____

♦ EMERGENCY ACTION PLAN ♦

If student has symptoms or you suspect exposure to their allergen:

1. **INJECT EPINEPHRINE IMMEDIATELY** – place auto-injector in sharps container after EMS depart.
2. **Adult should stay with student at all times.**
3. **CALL 911 and report that Epinephrine has been administered for an allergic reaction.**
4. **Note time of reaction. Note time(s) medication given.**
5. **Notify parent/guardian, school nurse and school administrator.**
6. **Lay student flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.**
7. **Consider giving additional ordered medications following the Epinephrine Auto-injector:**
   a. **Antihistamine** b. **Inhaler if wheezing or breathing difficulties**
8. **If symptoms persist, additional Epinephrine may be administered if ordered and available.**
9. **The student must be transported by medical personnel or a parent and may NOT remain at school.**
10. **Send a copy of the Confidential Health Form with EMS.**
11. **Complete Incident Report & 911 Checklist.**

My signature below gives permission for the school team to evaluate my child for a 504 plan based upon their allergy condition.
Parent Signature: _____ **Date:**_____

Form: 3416F1

Authorization for Administration of Medication at Elementary and Middle School

The following section is to be completed by the PARENT/GUARDIAN

(please print)

Student's Name: _____ Sex: _____
Last First

School: _____ Grade: _____ Birthdate: _____

Name of Medication: _____ Reason for taking it: _____

_____ _____ _____
Name of Physician/Health Care Provider Physician Phone # Physician Fax #

I request and authorize the school to administer the identified medication to the above student in accordance with the Health Provider's prescribed instructions, not to exceed the current school year. I give my permission for exchange of information between the School District staff and the Licensed Health Care Provider. I understand that the medication is to be furnished by me in the original container. For self-administration of inhaler or epi-pen, I authorize my child to carry and self-administer medication as specified. I shall hold harmless and indemnify the Issaquah School District's officers, employees and agents against all claims, judgments or liabilities arising out of the self-administration of medication as described.

Date: _____ Parent/Guardian Signature: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

The following section is to be completed by the PHYSICIAN/HEALTH CARE PROVIDER

(please print)

Diagnosis for which medication is given: _____

Name of medicine: _____

Dosage, time and mode of administration: _____

If medicine is to be given AS NEEDED, describe indications: _____

_____

If medication is prescribed for a limited length of time, please write duration: _____

List significant side effects: _____

Other information: _____

For inhalers - Student is capable of carrying and self-administration ☐ YES ☐ NO

For Epi-pen/Epi-pen Junior - Student is capable of carrying and self-administration ☐ YES ☐ NO

*Checking yes indicates that student has been instructed in the purpose and appropriate method/frequency of use.

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. Medication orders are good for the current school year, unless a shorter period is specified. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

Health Care Provider's Signature: _____

Health Care Provider's Printed Name: _____

Date: _____ Phone #: _____ Fax #: _____

School Nurse Approval: _____ Date: _____

Date: 09.24.86; 05.12.93; 06.26.96; 07.15.03; 06.02.06; 12.10.12; 10.26.15

Issaquah School District #411

Disaster Planning Authorization for the Administration of Medication for 72 hours at School

Student Name:_____ Birth Date:_____

School: _____ Grade: _____

I give my permission for exchange of information between the school district staff and the licensed health care provider.

Date: _____ Parent/Guardian Signature: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

Name of Medication Dosage Time of Day To Be Taken

_____

Diagnosis or reason for medication: _____

For inhalers student is capable self-administration: YES ☐ NO ☐

Possible side effects of medication: _____

Additional Instructions:_____

_____

I request/authorize the school to administer the above medication to the above identified student in accordance with the instructions indicated above for the period from _____ to _____

Licensed Health Care Provider Signature: _____ Date: _____

Telephone Number: _____ Fax Number: _____

Print Name: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Name of Medication Dosage Time of Day To Be Taken

_____

Diagnosis or reason for medication:_____

I request/authorize the school to administer the above medication to the above identified student in accordance with the Licensed Health Care Provider's instructions for the period from _____ to _____ (not to exceed current school year).

Parent/Guardian Signature: _____ Date: _____

Telephone Number: (Home) _____ (Work) _____ (Cell) _____

School Nurse approval: _____ Date: _____

Date: 09.24.86; 05.12.93; 06.26.96; 07.15.03; 06.02.06; 12.10.12