ALPHA ACADEMY SEVERE ALLERGY MEDICATION PLAN

To be completed by Medical Provider

MEDICATION ORDERS AND INSTRUCTIONS *(to be completed by the Student's Medical Provider)*

[PLEASE CHECK ☑ APPROPRIATE BOXES AND FILL IN THE BLANKS.]

Student's Name: _____ Wt: ____ *lbs.* DOB: _____ Age: _____

The above named person is a patient currently under my medical care. Due to a medical diagnosis of severe allergies, the medication listed below may need to be given during school hours according to the following protocol and the Alpha Academy Severe Allergy Emergency Plan of Action on page two:

List **SEVERE** allergies: _____

Type of exposure: ☐ Contact (skin) ☐ Ingestion ☐ Inhalation (airborne) ☐ Injection (insect bites/stings, allergy shots, etc.)

EPINEPHRINE AUTO-INJECTOR

- **DOSAGE**
  - ☐ 0.15mg/3ml (Inject into middle of outer thigh muscle)
  - ☐ 0.3mg/3ml (Inject into middle of outer thigh muscle)
- **TIME TO BE GIVEN**
  - ☐ Give immediately if known exposure/ingestion.
  - ☐ Give immediately if has symptoms of severe allergic reaction **(flushed face; dizziness; seizures; confusion; weakness; paleness; hives all over body; blueness around mouth, eyes; difficulty breathing; drooling or difficulty swallowing; loss of consciousness.)* Other: _____

☐ If second dose is available and symptoms continue or worsen, may give second dose at least <u>five</u> minutes after first dose.

*NC School Health Program Manual-2014 pg.E3-27

ORAL ANTIHISTAMINE ☐ NOT ordered for school

- **DRUG NAME** _____
- **DOSAGE** (Must be exact; Dose ranges not acceptable): _____
- **INTERVAL** every _____ hours as needed
- **TIME TO BE GIVEN**:
  - ☐ Give immediately if known exposure/ingestion.
  - ☐ Give immediately if has symptoms of mild allergic reaction **(red, watery eyes; itchy, sneezing, runny nose; hives or rash in one area.)*
  - Other _____

*NC School Health Program Manual-2014 pg.E3-27

- Is diet modification required: ☐ Yes or ☐ No
  If yes, **attach** completed Alpha Academy Medical Statement for Students with Special Nutritional Needs for School Meals Form.
- Is emergency self-medication to be considered: ☐ Yes or ☐ No
  If yes, **attach** completed Alpha Acdemy Emergency Self Medication Authorization Form. Only students mature enough to self-carry will be ~~given permission.~~

Physician's signature: _____

Print physician's name: _____ Date: _____ Phone: _____

Clinic address: _____ City: _____ State: ____ Zip:_____

To be completed by Parent or Legal Guardian

STUDENT INFORMATION *(to be completed by the Parent or Legal Guardian)*

Does your child have a 504 Plan? ☐ Yes or ☐ No Does your child have an IEP? ☐ Yes or ☐ No

<u>Transportation to and from school</u>:
☐ Walker: a.m. ___ p.m. ___ ☐ Car rider: a.m. ___ p.m. ___
☐ Bus rider: a.m. Bus No. _____ p.m. Bus No. _____
☐ Prime Time: a.m. ___ p.m. ___

Home address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Phone Number: _____ Alternate No. _____ Alternate No. _____

List other milder allergies and reactions: _____

Other health problems: _____

Current medications: _____

EMERGENCY CONTACTS: EMS will usually transport to nearest emergency department. Preferred medical facility: _____

_____ Relation: _____ Phone No. _____ Alternate No. _____

_____ Relation: _____ Phone No. _____ Alternate No. _____

RELEASE OF LIABILITY FORM: I, _____ the parent/legal guardia

_____ enrolled at _____

realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, Alpha Academy Schools, and the Alpha Academy Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

Parent or Guardian Signature: _____ Date: _____

Principal Signature: _____ Date: _____

FOR OFFICE USE ONLY: This order will expire 1 year from the date the physician signed. This form will expire on:_____

DISPOSITION OF MEDICATION: Date medication was picked-up _____ or date medication was discarded _____

by Staff Name:_____ Staff Signature: _____ Witness:_____

ALPHA ACADEMY SEVERE ALLERGY MEDICATION PLAN

Student's Name:_____DOB:_____Teacher:_____Grade:_____

INSTRUCTIONS FOR PERSON WITH STUDENT

1. Notify office to call 911 and request student's Emergency Allergy Medication Kit.
2. If insect sting occurred—remove stinger as quickly as possible and apply ice.
3. Reassure and calm student. Position student comfortably, sitting upright may be necessary for breathing ease.
4. When emergency allergy kit arrives, trained staff will administer epinephrine/antihistamine per physician's order.
5. Note exact time(s) medication was administered and inform EMS.
   - Epinephrine 1st dose was given at time: _____
   - If required, Epinephrine 2nd dose was given at time: _____
   - Antihistamine dose was given at time: _____
6. If student's condition is worsening and EMS has not arrived, have office call 911 and report the change.
7. EMS to transport to nearest emergency department or, if able, to parent's preferred medical facility.
8. If student has an allergic reaction on the bus then bus driver should stop route, call 911, and follow above instructions when possible.

INSTRUCTIONS FOR PERSON IN OFFICE

1. Kit should be taken to the student by an adult and 911 simultaneously called. The caller should state, "There has been a severe allergic reaction and I am a third party caller. Medical history includes: (see information listed on page one)."
2. Notify parent/ guardian as soon as possible.

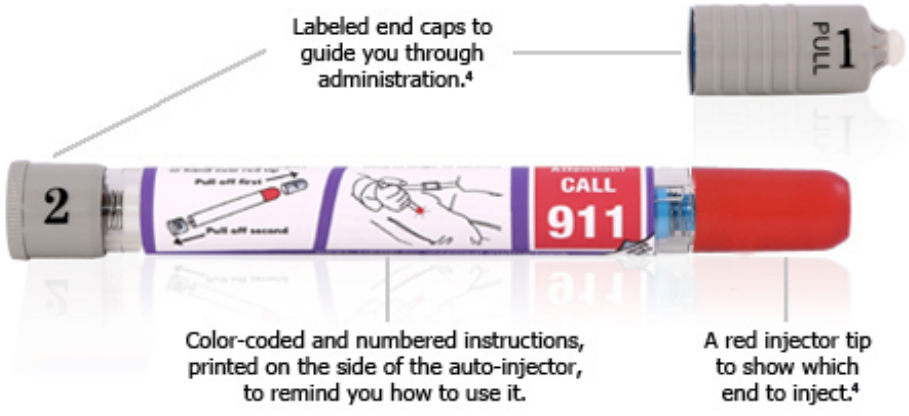
INSTRUCTIONS FOR PERSON INJECTING EPINEPHRINE

1. Put on gloves.
2. Make sure student is sitting or lying down.
3. Follow physician's orders.
4. Follow directions that are printed on the auto-injector.
5. Keep student warm and quiet. Massage injection site for ten seconds and apply Band-Aid, if needed.
6. If condition worsens or breathing stops, begin CPR and call 911 to report condition has worsened.
7. Send used kit with EMS for disposal in a sharps biohazard container.

FOLLOW-UP AFTER USE OF AUTO-INJECTOR

1. Contact parent regarding incident outcome and need for replacement.
2. Document incident on health card to include cause of allergic reaction, date and time of incident, symptoms displayed, and if any follow-up recommendations from physician.
3. School staff, administration, and school nurse will meet to discuss and evaluate incident.

Please note: brands differ and some require different delivery times for injection. Always read the enclosed instructions that accompany the auto-injector.



EMERGENCY MEDICATION INFORMATION *(to be completed by the school nurse)* **Nurse**: _____ **Date**: _____

LOCATION OF EMERGENCY MEDICATIONS: [Please check ☑ all that apply.]➔ ☐ School medication cart OR ☐ Prime Time OR ☐ Bus during route

1. School med cart Medication=Antihistamine-Exp. Date:_____ Epinephrine Auto-Injectors-#of doses ____ Exp. Date _____Lot# _____
2. Prime Time Medication=Antihistamine-Exp. Date _____ Epinephrine Auto-Injectors-#of doses _____ Exp. Date _____Lot# _____
3. Bus Medication=Antihistamine-Exp. Date_____ Epinephrine Auto-Injectors-#of doses _____ Exp. Date _____ Lot# _____