Parent ☐
Physician ☐

Bullitt County Public Schools

1040 Highway 44 East
Shepherdsville, Kentucky 40165

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

Moving Forward

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 2018-2019 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."

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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 Schools

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**

Signs of an allergic reaction include:

Systems:	**Symptoms**:
Mouth	itching and swelling of the lips, tongue, or mouth
Throat*	itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Stomach	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart*	"thready"pulse, "passing out"

***The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!**

May take Antihistamine for *mild* symptoms: ☐No ☐Yes, Type_____ Dose_____ *(must complete medication form 09.2241 AP .21)*

Emergency action for a severe allergic reaction:

1. Administer emergency medication*
   ☐Epinephrine Dose_____ *(must complete medication form 09.2241 AP .21)* Epinephrine Expiration Date: _____
2. Call EMS (911) & transport to: _____
3. Call Parent/guardian or emergency contacts immediately:

Epinephrine should be: ☐ **kept in classroom with teacher** ☐ **kept in front office** ☐ **kept with child with assist of adult (may require 504)**
☐ ****kept on their person –** (MD APPROVAL REQUIRED)

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

_____** (*MD INITIALS*) Student has been instructed by Physician regarding the care, storage, and use of the prescribed medication and has the ability to determine appropriate administration and usage of the above medication. The medication must be carried on the student's person at all times; during the school day, on field trips, and while participating in before or after school clubs/events/athletics.

_____ _____

✕**Printed Name of MD, ARNP, or PA** **Address**

_____ _____ _____

✕**Signature of MD, ARNP, or PA** **Telephone No.** **Date**

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed. Parent/Guardian also agrees that the replacement of expired medication is their responsibility. I hereby give permission for the above information to be verified with the above health care provider. I am fully aware and have been informed by the above primary care provider that my child's condition is of such a serious nature that, if it occurs, there would not be sufficient time to remove him/her from the school premises or to await the arrival of medical help. I hereby give my authorization and consent to trained non-medical school personnel to give prompt treatment, as specified above, to my child. I hereby agree to release and hold BCPS free and harmless for any claims, demands, or suits for damages from any injury and/ or complication that may result from such treatment or medication described by me or prescribed by my child's physician.

**If medication is to be on student's person, the parent/guardian agrees the medication will be carried in a secure, protective container and that the medication will be labeled with the student's name. When a student is authorized by their physician and parent/guardian to possess a prescribed life-sustaining medication, it is recommended that an additional dose of medication is kept in the school office. In the event the prescribed medication is discontinued by the physician, the parent/guardian will notify their student's school office by providing a written statement from the prescribing physician. The parent/guardian further agrees to indemnify and hold harmless any employee and the Bullitt County Board of Education and its members from any claim resulting from the student's self-administration per state law. The permission for self-administration of medication shall be in effect for the school year in which it is granted and shall be renewed each following school year.

✕**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:_____ **Reason for medication:**_____ **Instructions: Time:**_____ **Dose:**_____ **Start Date:**_____/_____/_____ **Stop Date:**_____/_____/_____	**Name of medication:**_____ **Reason for medication:**_____ **Instructions: Time:**_____ **Dose:**_____ **Start Date:**_____/_____/_____**Stop Date:**_____/_____/_____
Signs & symptoms of emergency administration: _____ Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:_____ ☐ Other *Student must carry this medication on his/her person and self-administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Signs & symptoms of emergency administration: _____ Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:_____ ☐ Other *Student must carry this medication on his/her person and self- administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)

_____***(MD INITIALS)** The above named student has been instructed on the care, storage, dosage, and use of the above medication(s) and has sufficient knowledge and ability to self-administer the medication(s) in the school setting and while on field trips.

_____
*Physician/Health Care Provider Signature/Date

Physician Practice name:_____

Address:_____

Phone: (___)_____ Fax: (___)_____

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 _____

Review/Revised: 6/19/2017

Consent Form for Mutual Exchange of Information

Student's Name: _____ Date: _____

Date of Birth: _____ Parent/Guardian: _____

Address: _____

I the parent/guardian of the above named student hereby authorize 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.

Name: _____ Phone #: _____
(Physician's name)

Address: _____

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 medical needs related to treatment for the following condition or injury _____ on or about _____
- ☐ Reviewing medical records covering the period of time _____ to _____
- ☐ Addressing issues related to the student missing school/excessive absences
- ☐ 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 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 Date

Public Law 93-380 (Federal Family Educational Rights and Privacy Act of 1974) specifically states that school records may be released to third parties provided:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. The reason for the release is stated.
3. The identity of the third party is specified.
4. The parents receive a copy of the record, if desired.
5. The records to be released are specified.

Review/Revised: 7/19/11