LUMMI NATION SCHOOL
Physician's Order and Emergency Care Plan
For Allergy/Anaphylaxis

➢ *This form must be fully completed to allow for school attendance per RCW 28A.210.320.*

Student_____ Birthdate_____ School_____

Identified Life-Threatening Allergen(s) are:
Other non-life-threatening allergens:
Diagnosis of Asthma? ❑ Yes ❑ No

Auto-injector will be stored: ❑ Main Office ❑ On Student ❑ Other: The student named above is authorized to self-administer the epinephrine auto-injector: ❑ Yes ❑ No

Physician's order for epinephrine auto-injector ❑ 0.15mg (junior) ❑ 0.3 mg (adult)

1. Administer auto-injector if student is unable or not authorized to self-administer **for suspected or actual exposure to above noted life-threatening allergen(s).**
2. Call 911
3. If other medication (ie: antihistamine) is needed, complete separate authorization form.

If epinephrine auto-injector is not immediately available, call 911.	
Symptoms of allergic reaction/anaphylaxis may include:	
Gastrointestinal:	*Nausea, stomachache, abdominal cramps, vomiting, diarrhea*
Heart:	*Passing out, fainting, pale or bluish skin color*
Lungs:	*Shortness of breath, repetitive coughing, wheezing*
Mouth:	*Itching, tingling, or swelling of the lips, tongue or mouth.*
Skin:	*Hives, itchy rash, swelling about the face or extremities*
Throat:	*Sense of tightness is the throat, hoarseness, hacking cough*
General:	*Panic, sudden fatigue, chills, fear*
Other:	*Some students may experience symptoms other than those listed above*

Medication Authorization: Health Care Provider and Parent/Legal Guardian signatures required:
I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for a potentially life threatening condition. I understand that trained unlicensed school personnel may be delegated to administer the emergency epinephrine auto-injector.

_____ _____
Health Care Provider (signature) Date

_____ _____
Health Care Provider (print name) Phone Number

➢ By signing this, I acknowledge that I have read and understand the information on page 2 of this form.

_____ _____
Parent/Legal Guardian (signature) Date

Parent/Legal Guardian – I understand the following:

- I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector.
- This order must be **renewed each school year.**
- It is recommended that my child wear a medical alert identification (i.e. bracelet or necklace).
- For afterschool activities, athletic events or any school related events outside the regular school-hours parent/legal guardian must make arrangements with the building or program administrator to assure access to epinephrine auto-injector.
- If my child is self-carrying and a back up epinephrine auto-injector is NOT provided to the school, **it is understood that my child is required by law to have it in his/her possession while attending any school sponsored event or activity. The availability of having this emergency medication in my child's possession is solely my child's responsibility and mine.**
- It is my responsibility to make sure that the epinephrine auto-injector(s) is current and unexpired.
- I will update this order if any allergens/conditions have changed.
- The school nurse will instruct the designated staff in the intervention protocol per licensed health care provider's order in the use of the epinephrine auto-injector and signs and symptoms of anaphylaxis.

LUMMI NATION SCHOOL
Authorization for Medications at School

Student_____ Birthdate_____ School_____ Year_____

Medication will be administered by trained designated school personnel to a student at school only when absolutely necessary per RCW 28A.210.260-270 and RCW 18.71.030 (3). The school accepts no responsibility for unanticipated reactions when the medication is administered in accordance with the directions of the student's Health Care Provider. Orders must be nondiscretionary and legible.

This form should <u>not</u> be used to prescribe emergency medications or injections. **<u>ONLY ONE MEDICATION PER FORM</u>**

Section #1: To be completed by the PARENT/GUARDIAN

Please check only on box:

❑ I request that authorized staff administer the medication indicated in section #2. Health Care Provider's signature needed.

❑ I request that my child be allowed to **self-administer <u>prescription</u>** medication indicated in section #2. Health Care Provider's signature needed.

❑ I request that my child be allowed to **self-administer <u>over-the-counter medication</u>** (RCW 26.28.015 or RCW 70.02.130). Parent must sign below and complete medication information in section #2. No Health Care Provider signature is needed.

- **By signing this, I consent to exchange of information regarding this medication authorization between the school and the Health Care Provider. I have read and understand the information on page 2 of this form.**

_____ _____ _____
Date Parent/Guardian Signature Phone

Section #2: To be completed by the HEALTH CARE PROVIDER (or parent, if over-the-counter self-administered)

This medication will be: ❑ Staff administered ❑ Self-administered (student has demonstrated the skill level necessary)

Diagnosis/reason for medication_____

Name of medication_____ Dose to be given_____

☐ Oral (MDI, Nebulizer inclusive) ❑ Topical ❑ Eye drops ❑ Nasal ❑ Rectal ❑ Other:_____

Specific Time(s) _____AM _____PM and frequency of administration _____

_____

Possible side effects_____

Length of prescription: ❑ Current school year (including summer school) ❑ Other:_____

I request and authorize that the above-named student be administered or be allowed to self-administer the above-identified medication in accordance with the instructions indicated.

_____ _____
Licensed Health Care Provider signature Date

_____ _____
LHCP printed name Telephone number

Parent/Guardian Information and Asthma Action Plan located on back of form.

OVER ⇨

PARENT/GUARDIAN INFORMATION REGARDING MEDICATIONS IN SCHOOL

I certify that I am the parent, legal guardian, or other person in legal control of this student. I request and authorize the school to administer the medication prescribed, as authorized by RCW 28.A210.260-270 and RCW 18.71.030 (3). This includes oral, inhaled, topical, nasal, rectal, eye and ear drops that shall be given at school **only when absolutely necessary**. Designated/trained employees shall administer this medication in compliance with Licensed Health Care Provider (LHCP) orders.

I understand the medication must be furnished in the **current, original container** from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and **must not** require any preparation by building staff. If the dosage or time should change, new orders and container will be provided.

I understand it is **the parents'** responsibility to deliver and maintain an adequate supply of the medication at school. The medication may not be delivered by the child or school bus driver. Medication delivered by the child or bus driver will NOT be dispensed.

I understand that it is the student's responsibility to come and receive his/her medication at the appointed time. I also understand that because of the school's schedule and other responsibilities of school staff members, there may be occasions in which a dosage may be delayed or missed.

I understand medication orders are only valid for the current school year (including summer school). Any medication remaining at the end of the school year, not picked up within 5 days after the last day of school, will be destroyed, with the exception of Extended School Year students.

As a general rule, the school will not administer prescribed medications during field trips. I understand that in those instances where medication must be administered I will make arrangements at least 24 hours prior to the field trip.

If self-administration is requested (and approved by principal/nurse), I certify that my child has the skill level necessary to do so, and that the school will assume no responsibility/liability for the administration of the medication or its use. Student may only carry a one day supply of oral medication.

ASTHMA ACTION PLAN

- ❑ **Intermittent** has symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside to these few episodes, a student is free of symptoms.
- ❑ **Mild** Symptoms occur more than twice a week but less than once a day, flare-ups may affect activity.
- ❑ **Moderate** Symptoms occur daily; flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.
- ❑ **Severe** Symptoms occur daily and often, also curtail the student's activities and disrupt sleep.

WARNING SIGNS OF AN ASTHMA ATTACK:	EMERGENCY RESCUE PLAN:
• Constant cough • Difficulty breathing with struggling or gasping for breath, or an audible wheeze with breathing • Stooped body posture • Trouble walking or talking, or stops playing and can't start activity again • Lips or fingernails are grey or blue (light complexion only) • _____	• Remove student from known triggers, if possible. • Accompany student to health room • Give medication as prescribed: • Keep student sitting up and reassure student • Encourage student to drink warm fluids
• No improvement 15-20 minutes after initial treatment with medication.	• Notify parent. • Call school nurse • If parents are unable to come within 10 min call 911
If student is in severe distress.	**Call 911.** Notify parent, principal and school nurse.

LUMMI NATION SCHOOL
Life Threatening Health Condition Status

Student	Birthdate
Primary Health Care Provider	Phone
School	School Nurse

A "life-threatening condition" (WAC 180-38-020) is defined as a health condition that will put the child in danger of death during the school day if medication or treatment order and a nursing plan are not in place. The medication or treatment order must address the "life-threatening condition" and it must be on file with the school along with medication and equipment prior to the child attending school.

Our records indicate a "health concern(s)" of: _____

_____

which, we believe would require a medication or treatment order and a nursing plan.

*Authorization for exchange of confidential information is attached.

A. To Be Completed by the Licensed Health Care Provider

The above named student has the following "life-threatening health condition" which requires a medication or treatment order and a nursing plan in place.

- Diagnosis: _____
- Treatment Plan: _____

_____

_____

- Medication form attached (if medication is to be administered). ☐ Yes ☐ No
  If no, indicate reason: _____

Health Care Provider Signature: _____ Date: _____

B. Notification of Student Health Status or Change in Status

If you feel this student's health condition does **not** meet the criteria of a "life-threatening condition" or no longer meets the definition of a life threatening condition, please discuss this with the parent/guardian of the above named student and return this form with the signatures below. It is imperative that both a parent and the health care provider are in agreement in this decision.

As the above student's health care provider, I do not believe this student has a diagnosis that would be considered (by definition above) as a "life threatening condition."

Health Care Provider Signature: _____ Date: _____

As the parent/guardian of the student named above and I have discussed the health concern noted above and agree that there is not a life-threatening condition as defined, which would require medication, treatment or nursing plan in place.

Parent/Legal Guardian Signature: _____ Date: _____