Bracken County School Health Program

Emergency Action Plan

Dear Parent/Guardian,

You have identified your child as having a **life threatening condition** that may require emergency treatment or medications to be given at school. Please complete the "Emergency Action Plan" for your child who may need emergency treatment for diabetes, asthma, severe allergies, seizures, or other serious medical conditions and return it to school.

Please contact the school health office if you need help completing the form.

Emergency situations may arise and it is important to have the needed information to care for your child.

There MUST be a written order, from your child's doctor, on file at the school for all prescription medications. There is an additional form that must be completed if you want your child to carry the emergency medication (i.e., inhaler, Epi-pen, Diastat, Glucagon,etc). Please contact the school nurse for any further questions.

Thank you,

Bracken County School Nurse

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ Date form received: _____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization. _____

Student Name: _____ Student age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

_____

Start: ☐ Date form received ☐ Other, as specified: _____

Stop: ☐ End of school year ☐ Other date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restriction

☐ Yes. Please describe: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other: _____

Physician's Signature _____ Physician's Name: _____

Date _____ Phone _____ Address: _____

For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy ONLY

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information

☐ On the back: side of this form ☐ As an attachment

Signature: _____ Date _____

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the Bracken County School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ Emergency phone: _____

Bracken County Health Department
PO Box 117, 429 Frankfort Street
Brooksville, KY 41004
(606) 735-2157

Place Child's Picture Here

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____
Student's Name: _____ D.O.B. _____ Teacher: _____

Asthmatic: Yes ( )* No ( ) *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
MOUTH	itching & 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
GUT	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!

ACTION:
If ingestion is suspected, give _____ immediately! and
Medication/dose/route
Call Rescue Squad: 911

Call Mother: _____ Father: _____

Or other emergency contacts at: Number listed on back of form.

Call Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____
Parent's Signature Date M.D.

Please complete emergency contact numbers on back of form.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

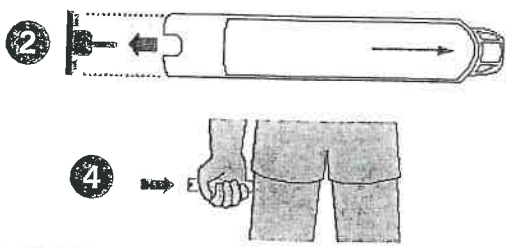
OVER

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

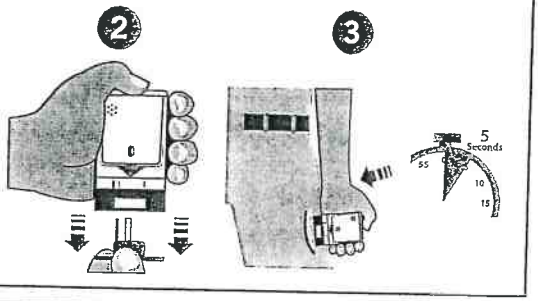
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



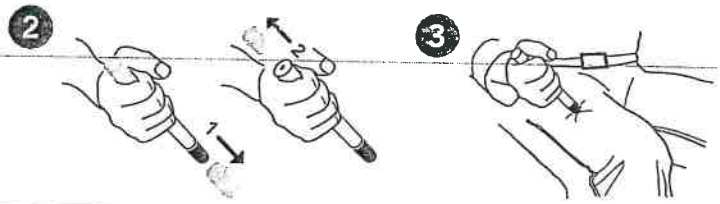
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat someone before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014