# CAMPBELL COUNTY SCHOOLS

# HEALTH SERVICES

**Diana Taylor, R.N.**
**District Health Nurse**

**909 Camel Crossing**
**Alexandria, KY 41001**

**Telephone: 635-4161**
**Ext: 2252**

Dear Parent/Guardian:

Campbell County schools is requiring all students who have allergies requiring emergency medications or treatment to have an Allergy Action Plan on file. This is to insure immediate and accurate treatment of your child in case of a reaction to an allergen.

Enclosed is the Action Plan. Both sides need to be filled out and signed by both the parent/guardian as well as the physician. If possible, please apply a picture of your child in the designated spot on the Action Plan.

Please understand this does not take the place of a meeting at the beginning of the school year. The school staff needs to be informed and updated yearly regarding your child's allergy. The Action Plan provides specific directions about what to do if your child experiences an allergic reaction and will be readily available if needed.

Thank you in advance for your cooperation. We at Campbell County want to insure your child's safety and well being at all times while attending school.

Sincerely,

Diana Taylor, R.N.
District Health Nurse
Campbell County Schools

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

**ALLERGIES: Individualized Health Care Plan (IHP)**

**SCHOOL YEAR** _____

**Student Name:** _____ **DOB:** _____ **Grade:** _____

**School:** _____ **Bus# AM:** _____ **Bus# PM:** _____ **Car Rider** ___

**ALLERGIC TO:** _____

***HISTORY OF ALLERGIC REACTIONS *** Number of reactions ____ Date of last reaction _____

What treatment was provided: _____

| | | | |
|---|---|---|---|
| Asthma | Yes _____ | No _____ | Children with asthma are at high risk for severe reaction |
| Inhaler at School | Yes _____ | No _____ | |
| Medical I.D. worn | Yes _____ | No _____ | |

---

*** SIGNS OF AN ALLERGIC REACTION *** NOTE: Severity of symptoms can change quickly

| Systems: | Symptoms: |
|---|---|
| * Mouth | Itching, tingling, & swelling of the lips, tongue, or mouth |
| *Skin | Hives, itchy rash, and /or swelling about the face or extremities |
| *Gut | Nausea, abdominal cramps, vomiting, diarrhea |
| **!!Throat** | Irritation and /or a sense of tightness in the throat, hoarseness, and hacking cough |
| **!!Lungs** | Shortness of breath, repetitive coughing, and/or wheezing |
| **!!Heart** | Thready pulse, fainting, pale, blueness |
| *Other | _____ |

**!! Potentially life threatening**

---

*** ACTION FOR MINOR REACTION ***

1. If the only symptom(s) are: _____

   _____

   **Give**: _____
   Medication/ dose/ route
2. **Call**: Mother, father, or emergency contacts. See phone numbers below.

**If condition does not improve within 10 minutes, follow steps for Major Reaction below.**

---

***ACTION FOR MAJOR REACTION ***

1. If ingestion is suspected and/or symptom(s) are: _____

   _____

   **Give:** _____
   Medication/ dose/ route
2. **Call: 911! Do not hesitate. Ask for advanced life support. State than an allergic reaction has been treated and additional epinephrine may be needed.**
3. **Call:** Mother, father, or emergency contacts. See phone numbers below.

| Name | Relationship | Phone Numbers | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Physician Signature: _____ Date: _____

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**
**CAMPBELL COUNTY SCHOOLS**

STUDENT'S FULL NAME_____ Date of Birth_____

Address: _____ Social Security Number:_____

_____

Specific type of information being requested:
___History and Physical
___Educational Evaluations
___Speech/Language Evaluations
___Occupational Therapy/Physical Therapy Evaluations
✓School Recommendations
✓Medical Information that Impacts School Performance (including medications)
___Other:
___Other:
___Other:

The information indicated above shall be disclosed to:

Name Diana Taylor RN Name_____

Agency/School CCHS Agency/School_____

Title Health Services Coord. Title_____

Address 909 Camel Crossing Address_____

Alexandria, KY 41001 _____

Phone (859) 635-4161 Fax (859) 448-4886 Phone_____ Fax_____

This authorization will be valid for the 2016-2017 school year and may be revoked, in writing, at any time by parent/guardian. It is understood that information disclosed/action taken prior to the revocation cannot be reversed. Any information disclosed will become a part of the student's permanent school record.

I, _____, parent/guardian of student named above, authorize the release of the information indicated above by:

Name/Organization: _____

Address: _____

_____

Phone: _____

to the representative(s) of Campbell County Schools.

X Signature_____ Date_____

___Parent ___Legal Guardian ___Student (if of legal age)

X Witness_____ Date_____

CAMPBELL COUNTY SCHOOLS

**Authorization to Carry/Self-Administer Medication**

Pursuant to the laws of the Commonwealth of Kentucky and Campbell County Schools Board Policy, students may be granted permission to carry and self-administer medication only for emergency use during school hours and during school sponsored activities. This is limited to medication for treatment of asthma, severe allergic reaction, or diabetes. The student must have training in the proper use of the medication named and be responsible for safe use.

---

Name of Student_____ DOB_____ School_____ Grade___

Condition for which Medication is prescribed_____

Name of Medication_____

Dose of Medication and route_____

Time and Indication for Administration_____

Side effects to be noted/reported_____

Other recommendations: _____

Length of time Medication is authorized:. From_____ to_____ (Limit of 1 school year)

Date Authorization received by school: _____

**In my opinion, this student shows capability to carry and self-administer this medication as ordered above.**

Physician Signature_____ Printed Name_____
Phone number_____ Date_____

**********

**Parent/Guardian Authorization**

I request that my child be permitted to carry and self-administer the medication ordered above. I understand the medication must be in its original prescription container. I accept responsibility for this permission and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

Signature of Parent/Guardian _____ Date _____

**Revised 4/04**

# Campbell County Schools Health Services

## Consent Form for Administering Medication at School

Student's Name _____ Grade _____

Name of Medication _____

Dosage _____

Time(s) to be Given _____

Route of Administration _____

Diagnosis or Reason for Medication to be Given _____

Possible Side-Effects: _____

Student's Allergies: _____

Name of Prescribing Doctor _____ Phone _____

_____ _____

Signature of Prescribing Doctor Date

---

I request my child be permitted to take medications as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____

Signature of Parent/Guardian Date

_____

Name of School Submitted to

Revised 7/09

# Campbell County Schools Health Services

## Consent Form for Administering Medication at School

Student's Name _____ Grade _____

Name of Medication _____

Dosage _____

Time(s) to be Given _____

Route of Administration _____

Diagnosis or Reason for Medication to be Given _____

Possible Side-Effects: _____

Student's Allergies: _____

Name of Prescribing Doctor _____ Phone _____

_____ _____

Signature of Prescribing Doctor Date

---

I request my child be permitted to take medications as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____

Signature of Parent/Guardian Date

_____

Name of School Submitted to

Revised 7/09

# Campbell County Schools Health Services

## Administration of Medication at School

Since it is recognized that some students are able to attend school because of the effectiveness of medications in the treatment of chronic disabilities and illnesses, this procedure has been adopted to help insure safe administration of medications in school.

A. No medication, prescription or over-the-counter, may be administered to students by an employee of the Campbell County Board of Education unless the **Consent Form for Administering Medications at School** form is filled out and signed by both the physician and parent/guardian. No handwritten notes by parent/guardian will be accepted.

B. Only doses of medication that cannot be administered at home will be given at school. Medication will not be administered at school due to convenience.

C. Any student who is required to take medication during regular school hours shall comply with the following:

1. No medication will be supplied by the school.
2. Prescription medications shall be brought to school in the original container that is properly labeled with the following information:
    a. Name of student
    b. Name of medication
    c. Dosage of Medication
    d. Time medication is to be administered
3. Nonprescription medication must be brought to school in original container and will only be administered with a physician signature on the appropriate Campbell County Schools Medication Consent form.
4. No medication, prescription or nonprescription, may be transported by the student on the school bus.
5. Medications should be provided in the form that it is to be administered. School staff will not divide tablets, etc.
6. School staff will not administer the first dose of any newly prescribed medication.
7. All medication will be kept in the school office in a specified safe place. Students are not permitted to have medication in their possession.
8. Self-managed/self-carry administration of emergency medication (insulin, inhalers, Epi-Pens) will be permitted with written authorization of parent and physician on the appropriate Campbell County Schools Self-Carry form.
9. It is the student's responsibility to comply with the doctor's order concerning administration of medications. Upon receipt of the signed consent form, school personnel will endeavor to assist students with medications.
10. All prescription medication amounts will be verified by nurse and parent/guardian upon initial arrival to office.
11. Every dose of medication administered by school personnel shall be recorded on a prescribed form.
12. Medications that contain narcotics or sedation for pain will NOT be administered at school to help Insure student safety.

******School personnel responsible for administration of medications will refuse to administer medication if the above guidelines are not followed. In such situations, the parent/guardian will be notified.*******

## AGREEMENT FOR THE ADMINISTRATION OF EMERGENCY CARE

The undersigned parent/guardian of _____
a pupil in the Campbell County Public Schools, has advised the Board of Education of Campbell County that his/her child named above suffers from a medical condition which may be life threatening unless immediate emergency care is provided in a crisis which may arise from the child's health problem.

Accordingly, the Board of Education of Campbell County has adopted a procedure wherein a member of the staff of the school the child is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the child's physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.

The undersigned parent/guardian does hereby consent to the intervention of the volunteer staff member in accordance with the instructions contained in the attached letter from the child's physician. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

Dated at Alexandria, Kentucky, this the _____ day of _____. _____
(Day) (Month) (Year)

X _____
(Parent/Guardian Signature)