

CHESTERFIELD COUNTY PUBLIC SCHOOLS
CHESTERFIELD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools and Chesterfield County Health Department. This includes preventing and managing severe allergic reactions so that all students can fully and safely participate in school activities.

You have indicated that your child has a severe allergy. Students with severe allergies may require the administration of emergency medication during the school day.

Chesterfield County Public Schools' Administration of Medication to Students (regulation 4130) requires proper documentation be on file at school for any medication used at school. It may be required for some students with severe allergies to carry emergency medication with them. In order to meet your child's health needs in school, we need you to complete the following steps:

- Have your child's healthcare provider complete and sign the enclosed Standard Health/Emergency Plan for Severe Allergy. A healthcare provider's written order and parent/guardian authorization are required for a student to carry and self-administer emergency medication for a severe allergic reaction at school.
- Provide your signature on the Standard Health/Emergency Plan.
- Return the completed form to the public health nurse at school as soon as possible.
- Complete the Chesterfield County Public Schools Medication Administration Request form. These forms are kept in the school clinic. Please see the CCPS parent handbook for details regarding general medication policies.

If you have any questions, call the public health nurse at your child's school or contact Chesterfield County Health Department School Health Services at (804) 748-1633. Thank you for your cooperation.

Sincerely,

Chesterfield County Health Department
School Health Services
P.O. Box 100
Chesterfield, Va. 23832
(804) 748-1633

Attachment

CHESTERFIELD COUNTY PUBLIC SCHOOLS
 CHESTERFIELD COUNTY HEALTH DEPARTMENT
 SCHOOL HEALTH SERVICES
CONFIDENTIAL Standard Health/Emergency Plan

May place student's
picture here if
desired

Student: _____ DOB: _____

School: _____ Grade/Teacher _____

SEVERE ALLERGY to _____

Student has asthma YES (higher risk for a severe reaction) NO

TO BE COMPLETED BY HEALTHCARE PROVIDER:

SYMPTOMS – occur due to: INGESTION INHALATION TOUCH/SKIN CONTACT INJECTION/STING

IF CHECKED, GIVE EPINEPHRINE IMMEDIATELY FOR ANY SYMPTOMS IF EXPOSURE TO THE ALLERGEN WAS LIKELY.

SEVERE REACTION	MILD REACTION
<p>FOR SYMPTOMS OF ANAPHYLAXIS:</p> <p><input type="checkbox"/> Administer Epinephrine Auto-Injector (per doctor's order below)</p> <ul style="list-style-type: none"> Call 911 immediately. Notify parent if not already contacted. Keep student calm. Remain with student and observe for difficulty breathing until rescue squad arrives. 	<p><input type="checkbox"/> Administer Antihistamine (if prescribed below)</p> <ul style="list-style-type: none"> Remain with student and observe for difficulty breathing. Contact parent. Apply ice to area if insect bite. Keep student warm. Monitor for progression of symptoms. <p>For the following symptoms:</p> <hr/> <p><i>If symptoms worsen or do not improve in 10 minutes, follow interventions for severe reaction.</i></p>

ADMINISTER THE FOLLOWING MEDICATIONS:

MEDICATION (Brand)	DOSAGE	INSTRUCTIONS
Epinephrine:		
Antihistamine:		
Inhaler:		

HEALTHCARE PROVIDER:

This student needs to carry his/her prescribed Epinephrine Auto-Injector at all times. YES NO
 If NO, medication will be stored in school clinic.

I verify he/she is capable and responsible for self-administering the medication.

This student **can self-administer the medication with assistance.** This student **cannot self-administer the medication.**

Healthcare Provider (Print Name) **Healthcare Provider (Signature)** **Date**
 Office Phone (____) _____ Office Fax (____) _____

I approve this Severe Allergy Standard Health/Emergency Plan for my child, and give permission for school personnel to follow this plan, administer medication and care for my child, and contact my child's healthcare provider if necessary. I assume full responsibility for providing the school with prescribed medication for my child.

Parent/Guardian (Print name) **Parent/Guardian (Signature)** **Date**

Public Health Nurse Special Education Nurse **Nurse (Signature)** **Date**

Annual Review Date: _____ Comments: _____ Nurse: _____
 Annual Review Date: _____ Comments: _____ Nurse: _____
 Annual Review Date: _____ Comments: _____ Nurse: _____
 Annual Review Date: _____ Comments: _____ Nurse: _____

Resource – FAAN (www.foodallergy.org)