

STUDENTS

Health Services – Allergic Reactions

When a student's physician prescribes emergency allergy injections and related medication (Epinephrine Auto-Injection), and there is the possibility that a student might need this treatment during the regular school or School Age Child Care (SACC) hours, the following procedures shall be implemented:

1. Two staff members shall be identified to learn the procedure. These two persons shall be trained by a school nurse in the Prince William County Public School (PWCS) Division.
2. The two persons trained shall be regular members of the school staff, which ensures at least one of the two being present during school hours.
3. For students who have an epinephrine auto-injector at school/SACC, parents/guardians must notify the teacher/sponsor about the child's allergy when the student will be staying for any school-sponsored after school activities. The clinic is closed after dismissal and the nurse/health clinic assistant is not in the building. It is strongly suggested that middle and high school students carry their own auto-injector for quick access to epinephrine. For students to carry an epinephrine auto-injector, the physician, parent/guardian, and student will need to sign and date the Permission for Student to Carry and/or Self Administer Epinephrine form (Attachment I, Part 4). The Department of Social Services licensing does not allow students in SACC to self-carry or self-administer epinephrine. Parents/guardians will be notified prior to child's enrollment in SACC.
4. Any school staff member or child care contractor (CCC) may, without prejudice, decline to accept responsibility for administering the epinephrine medication to the student.
5. Physician's written prescribed medication authorization form (Attachment I, Part 2) and parent/guardian request for administration of medication for allergic reactions (Attachment I, Parts 1-3) shall be completed and signed prior to administration of medication by any PWCS or CCC employee.
6. Self-carrying of prescribed epinephrine requires written consent of a licensed healthcare provider and an Allergy Action Plan (AAP) completed and on file at the school and SACC (Attachment I, Parts 1-4).
7. A copy of the completed AAP, Severe Allergy Individual Health Care Plan (SAIHCP), and the procedural guidelines to be followed must be filed with the school and SACC. The prescription must state:

- a. Name of procedure/medication to be administered.
  - b. Statement of dosage for injection.
  - c. Specific symptoms for administering medication.
8. All medications shall be stored together in an easily accessible locked area. Parents/guardians shall be responsible for ensuring that the medication has not exceeded the expiration date.
  9. Any person who, in good faith and without compensation, administers medication to an individual for whom epinephrine has been prescribed shall not be liable for any civil damages for acts or omissions resulting from the rendering of such treatment if he/she has reason to believe that the individual receiving the injection is suffering, or is about to suffer, a life-threatening anaphylactic reaction.
  10. An AAP shall be effective for one school/SACC year and must be renewed annually.
  11. Guidelines for the “Management of Life-Threatening Allergies in Schools and School Age Child Care” was developed to assist PWCS in implementing comprehensive procedures which promote healthy nutrition for all students with emphasis on students with life-threatening food allergies. This document may be found on the Office of Student Services Web page under School Health Services.

The Associate Superintendent for Student Learning and Accountability (or designee) is responsible for implementing and monitoring this regulation.

The Associate Superintendent for Student Learning and Accountability (or designee) is responsible for reviewing this regulation in 2017.

Legal References:

Virginia Codes §§ 8.01-226.5:1 and 22.1-274.2

**Allergy Action Plan**

Student:	School:	Effective Date:
Date of Birth:	Grade:	Teacher:

Dear Parent or Guardian: Please provide the information requested below to help us care for your child at school.

Part 1 - Provides medical history and contact information. To be completed by parent/guardian.

Part 2 - Provides healthcare provider authorization to administer medication during an allergic reaction. To be completed by healthcare provider.

Part 3 – Provides parent/guardian authorization to provide care. To be completed by parent/guardian.

Part 4 – Provides authorization when a student is to carry and self-administer epinephrine. To be completed by healthcare provider, parent/guardian, and student.

Please note: Allergy Action Plans must be submitted annually at the beginning of each school/SACC year and whenever modifications are made to this plan.

<b>Part 1: To be Completed by Parent/Guardian</b>
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Contact Information		
Parent/Guardian #1:		
Address:		
Telephone – Home:	Work:	Cell:
Parent/Guardian #2:		
Address:		
Telephone – Home:	Work:	Cell:
Other emergency contact:		
Physician’s Name:		Office phone:
Medical History		
What is your child allergic to?		
What age was your child when diagnosed?		
Has your child ever had a life-threatening reaction?		
What is your child’s typical allergic reaction?		
Does your child have asthma?		
Does your child know what food/allergens to avoid?		
Will your child eat the school provided breakfast and/or lunch?		
Will you be providing meals and snacks for your child at school/SACC?		
How does your child travel to school/SACC?		
<input type="checkbox"/> Bus # _____ <input type="checkbox"/> Car <input type="checkbox"/> Walk		

Allergy Action Plan

**Part 2: To be Completed by HealthCare Provider**








Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 Allergy to: \_\_\_\_\_  
 Weight: \_\_\_\_\_ lbs.      **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

**PLACE  
 STUDENT'S  
 PICTURE  
 HERE**

**For a suspected or active food allergy reaction:**

FOR ANY OF THE FOLLOWING  
**SEVERE SYMPTOMS**





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

			
<b>LUNG</b>	<b>HEART</b>	<b>THROAT</b>	<b>MOUTH</b>
Short of breath, wheezing, repetitive cough	Pale, blue, faint, weak pulse, dizzy	Tight, hoarse, trouble breathing/ swallowing	Significant swelling of the tongue and/or lips
			<b>OR A COMBINATION of mild or severe symptoms from different body areas.</b>
<b>SKIN</b>	<b>GUT</b>	<b>OTHER</b>	
Many hives over body, widespread redness	Repetitive vomiting or severe diarrhea	Feeling something bad is about to happen, anxiety, confusion	

**NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.**

**MILD SYMPTOMS**

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

	
<b>NOSE</b>	<b>MOUTH</b>
Itchy/runny nose, sneezing	Itchy mouth
	
<b>SKIN</b>	<b>GUT</b>
A few hives, mild itch	Mild nausea/discomfort

↓      ↓      ↓

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

**NOTE:** Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. Use Epinephrine.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.
  - Consider giving additional medications (following or with the epinephrine):
    - » Antihistamine
    - » Inhaler (bronchodilator) if asthma
  - Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

**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 asthmatic): \_\_\_\_\_

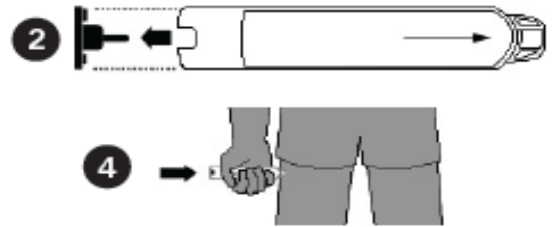
\_\_\_\_\_

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

Allergy Action Plan

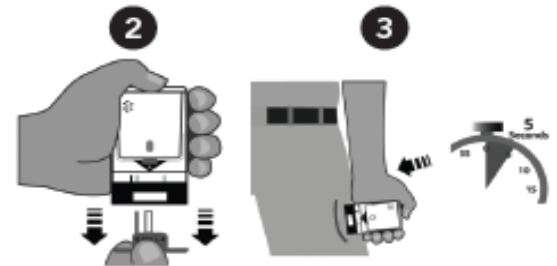
**EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS**

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 student 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

Allergy Action Plan

**Part 3: To be Completed by Parent/Guardian**

**PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION  
FOR ALLERGIC REACTIONS**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

Schools must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. When signed by the parent/guardian this written informed consent gives trained school/CCC staff authorization to implement the medical order. When parents/guardians authorize a medical treatment for their child in school/SACC such authorization includes permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment ordered. Health treatment plans not signed and dated by the parent/guardian will not be implemented until all signatures have been obtained. Legally appropriate school health professional-medical prescriber communications based on the medical orders generally include the following:

- The prescription of treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions);
- Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control, issues, or modifications in the treatment order related to the school setting or student’s academic schedule); and
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possibly untoward reactions, observation of behavior in the classroom).

Student may not attend school until the written parental/guardian authorization has been signed and returned to the school.

In accordance with the Virginia Code § 22.1-274, I agree to the following:

I will not hold the School Board, any of its employees, or CCC liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

\_\_\_\_\_  
Print Parent’s/Guardian’s Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent’s/Guardian’s Signature

\_\_\_\_\_  
Date

Designated School/CCC Staff Trained on the above named student's Allergy Action Plan

Printed Name	Signature	Trainer's Signature	Date of Training
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
Signature of School Nurse

\_\_\_\_\_  
Date

Allergy Action Plan

**Part 4: (Optional) Permission to Carry and/or Self-administer**

**PERMISSION FOR STUDENT TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, as the healthcare provider, certify that this child has a medical history of severe allergic reaction and has been trained in the use of the prescribed medication and is judged to be capable of carrying and self-administering epinephrine. The nurse or designated school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medication with others and has agreed to refrain from this practice. I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

- Self-carry
- Self-administer

\_\_\_\_\_  
Student Signature                                  Print Student Name                                  Date

\_\_\_\_\_  
Healthcare Provider Signature                                  Print Healthcare Provider Name                                  Date

\_\_\_\_\_  
Parent's/Guardian's Signature                                  Date

\_\_\_\_\_  
Principal/Designee Signature                                  Date



Prince William County Public Schools  
Severe Allergy Individual Health Care Plan

Place  
Student's  
Picture  
Here

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Teacher's Name \_\_\_\_\_ Lunch Time \_\_\_\_\_

Classroom

- Any food given to student must be approved by parent/guardian.
- Emergency food provided by parent/guardian to be kept in the classroom.
- Parent/guardian should be advised of any planned parties as early as possible.
- Classroom projects involving food should be reviewed by the parent/guardian and the teaching staff.
- Middle school or high school student will be making his/her own decision.  YES  NO

Bus

- Transportation will be alerted to student's allergy.
- This student has a physician's order to carry epinephrine on bus:  YES  NO
- Epinephrine can be found in:  backpack  waist pack  other (specify) \_\_\_\_\_
- Student will sit at front of bus:  YES  NO

Field Trip Procedures

- Parent/guardian should be notified early in the planning to address any risk of allergen exposure.
- Epinephrine should accompany student during any off campus activity.
- The elementary student should remain with the teacher during the entire field trip.
- Middle school/high school student should remain with the teacher during the entire field trip.  YES  NO

Cafeteria

- Food Service Manager and cafeteria hostesses will be alerted to the student's allergy.
- Cafeteria tables where food allergic students eat will be cleaned to eliminate food allergens.
- Student will sit at a specified allergy table.  YES  NO
- Student will sit at the classroom table at a specified location.  YES  NO
- **NO** restrictions where student may sit in the cafeteria.  YES  NO

Students must use their account cards (at elementary) or student identification number (at middle and high school) to identify their allergy to ensure their selections are double checked for safety.

Cafeteria menu is available online.

Parents/guardians are encouraged to make food choices from the menu.

Complete list of menu ingredients can be accessed through the School Food and Nutrition Services Web site.

YES  NO My child's severe allergy concerns require a meeting with school/SACC staff to discuss the classroom care plan. Additional accommodations will be discussed at this time.

\_\_\_\_\_  
Parent's/Guardian's Signature Date

\_\_\_\_\_  
School Nurse's Signature Date

\_\_\_\_\_  
School

**Physician's Statement for Students with Special Dietary Needs**

Place Student's Picture Here
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Physician's Statement for Students with Special Dietary Needs*		
Student's Name	Age	
Name of School	Grade Level	Classroom
Does the student have a disability? If Yes, describe the major life activities affected by the disability.	Yes	No
Does the student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.	Yes	No
If the student is not disabled, does the student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.	Yes	No
List any dietary restrictions or special diet.		
List any allergies or food intolerances to avoid.		
List foods to be substituted.		
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:		
List any special equipment or utensils that are needed.		
Indicate any other comments about the student's eating or feeding patterns.		
Physical or Medical Authority's Signature	Date	

\*This statement must be updated annually.