Alta Loma School District

Allergy Packet

Please complete the following forms to better help us understand your child's health condition and provide a safe and healthy school environment.

- □ Authorization for Exchange of Information (Signature needed)
- □ Questionnaire (Signature needed)
- □ Authorization for Medication at School (Signature from parent and doctor needed)
- □ Medication Policy

If you have any questions or concerns please feel free to email any one of the Nurses below. We appreciate your help in providing the best care for your child.

Sincerely,
Alta Loma School District Nurses

Erin Stevens, MSN, RN
estevens@alsd.org

Karen Simon, MSN, RN
ksimon@alsd.org

Patti Boyle, BSN, RN
pboyle@alsd.org

Alta Loma School District

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION

To Whom It May Concern:

I hereby give my permission for the exchange of immunization/medical information contained in the record of my child:

_____ _____ _____

Name of Student Birthdate Medical Record # (If applicable)

Between_____ and_____

(Name of Physician) (School Nurse)

Address: _____ School Stamp:_____

Physician Phone: _____ Fax: _____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

_____

Parent(s)/Guardian (Print)

_____ _____

Signature of Parent(s)/Guardian Date

Sincerely,
Alta Loma School District Nurses

Alta Loma School District

Allergy Health History Form

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Today's Date: _____

Home Phone: _____ Work:_____ Cell:_____

Primary Healthcare Provider: _____ Phone:_____

Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ☐ NO ☐ YES

2. History and Current Status

A. What is your child allergic to? ☐ Peanuts ☐ Insect Stings ☐ Eggs ☐ Fish/Shellfish ☐ Milk ☐ Chemicals ☐ Latex ☐ Vapors ☐ Soy ☐ Tree Nuts (Walnuts, Pecans) ☐ Other:_____	B. Age of student when allergy discovered:_____ C. How many times has the student had a reaction? ☐ Never ☐ Once ☐ More than once, explain below: _____ D. Explain their past reaction(s):_____ _____ E. Symptoms:_____ _____

3. Trigger and Symptoms

A. What are the early signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say) _____

_____

B. How does your child communicate his/her symptoms? _____

C. How quickly do symptoms appear after exposure to food(s)? _____

D. Please check the symptoms that your child has experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling

Mouth: ☐ Itching ☐ Swelling (lips, throat, mouth)

Stomach: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough

Lungs: ☐ Wheezing ☐ Cough ☐ Shortness of Breath

Heart: ☐ Weak Pulse ☐ Loss of Consciousness

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4. Treatment

A. How have past reactions been treated? _____

B. How effective was the student's response to treatment? _____

C. Was there an emergency room visit? ☐ No ☐ Yes, explain: _____

D. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____

E. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

_____

F. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

G. Have you used the treatment or medication? ☐ No ☐ Yes

H. Please describe any side effects or problems your child had in using the suggested treatment:

_____

5. Self-Care

A. Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes

B. Does your student:

1. Know what foods to avoid? ☐ No ☐ Yes
2. Ask about food ingredients? ☐ No ☐ Yes
3. Read and understand food labels? ☐ No ☐ Yes
4. Tell an adult immediately after an exposure? ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace or watchband? ☐ No ☐ Yes
6. Tell peers and adults about the allergy? ☐ No ☐ Yes
7. Firmly refuses a problem food? ☐ No ☐ Yes

C. Does your child know how to use emergency medication? ☐ No ☐ Yes

D. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy? _____

b. Has your child ever needed epinephrine administered? ☐ No ☐ Yes

c. Do you feel that your child needs assistance in coping with his/her food allergy?

_____

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7. General Health

a. How is your child's general health other than having a food allergy?

_____

b. Does your child have other health conditions?

_____

c. Hospitalizations?

_____

d. Does your child have a history of asthma? ☐ No ☐ Yes

e. Please add anything else you would like the school to know about your child's health:

_____

_____

8. Notes:

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by R.N.: _____ **Date:** _____

Alta Loma School District

AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Exception: California Education Code 49423.5 specialized services, i.e., Epipen, nebulizer, glucagon, insulin, diabetes care, etc. may require additional forms and instructions signed by parents or legal guardian and physician. **This form is valid for *only* one school year**.

1. Parent or Legal Guardian Section

Note: All medications must be prescribed, including, over the counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician.

I request that the designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse (or designee) to communicate with my child's prescriber and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees, harmless, for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I agree to comply with the district rules related to administering medication at school.

_____ □M □F _____

Name of Child Sex Date of Birth

_____ _____

Name of School Grade

I will *immediately* notify the school if there are any changes in medications my child is taking at school.

_____ _____ _____ _____

Signature of Parent of Legal Guardian Date Home Phone Work Phone

2. Physician Section

The child named above is under my care. It is necessary for him/her to receive the following prescribed medication during school hours.

Diagnosis for which medication is prescribed_____

Name of medication (one medication per form) _____

Dosage (Be specific, i.e., milligrams, etc.) _____

Time of day to be given_____

Frequency and Indication if "as needed"_____

If "as needed" described indications and sequence orders_____

Method of administration

ORAL: □Liquid □Tablet □Inhaler

DROPS: □Eye _R _L □ Ear _R _L □Nostril _R _L

OTHER: □ Topical □Other_____

Precautions or side effects_____

Storage and handling -Routine handling, medication in locked storage and administered by trained personnel_____

Additional special instructions_____

Office Stamp _____

_____ _____

Signature of Physician Date

_____ _____

Name of Physician (Please Print) Office Telephone

Alta Loma School District

INFORMATION FOR PARENTS OF STUDENTS NEEDING TO TAKE MEDICATION AT SCHOOL

Dear Parent/Guardian,

It is generally better to have medication administered at home; however, sometimes it is necessary for a child to take medication during school hours and we wish to assist you as needed. The school nurse serves several schools and is not available to help students take medication on a daily basis, so medically untrained, unlicensed school personnel most often perform this function. **Consequently we urge you, with the help of your health care provider, to work out a schedule to give medication outside school hours.**

In compliance with California Education Code 49423, when an employee of the school district helps a student take medication, the employee must be acting in accordance with the written directions of a person licensed to prescribe medications and with the written permission of the child's parent or legal guardian. These authorizations must be renewed whenever the prescription changes and at the beginning of each school term. ***THE INSTRUCTION LABEL ON PRESCRIPTION MEDICATIONS WHICH IS APPLIED BY THE PHARMACIST IS NOT ACCEPTABLE AS A PHYSICIAN'S STATEMENT. A PRESCRIPTION IS ALSO REQUIRED FOR OVER THE COUNTER MEDICATIONS. CHILDREN MAY TAKE MEDICATIONS AT SCHOOL ONLY WHEN A LEGAL PRESCRIPTION AND WRITTEN PARENT AUTHORIZATION ARE ON FILE.*** Prescriptions which are faxed to us must be followed by the original written prescription. Please ask your healthcare provider to mail the original at the time the fax is sent.

All medication must be stored in the health office. Children are not allowed to have medication in their possession at school, walking to and from school or on the school bus. This policy provides for the safety of all students on campus. The only exception to this policy is if the student's well-being is in jeopardy unless the medication, such as an inhaler for asthma, is carried on his/her person. The appropriate release forms can be obtained from the school and must include a statement from the physician that the student's well-being is in jeopardy unless he/she carries the medication.

Medication must be provided to the school in the container in which it was purchased, with the prescription label attached, and must be prescribed to the student who will take the medication. Students may not take medication brought to school in a plastic bag, plastic ware, or any other repackaging. Students may not take out of date medication at school. An adult must bring the medication to school along with the completed authorization form/s.

If you anticipate a visit to your child's physician or dentist and expect that medication may be prescribed or the dosage changed, please stop by the school office for the appropriate forms.

Thank you.

ALTA LOMA SCHOOL DISTRICT NURSES

Erin Stevens MSN, RN
District School Nurse

Karen Simon MSN, RN
District School Nurse

Patti Boyle, BSN, RN
District School Nurse