Brandon Valley School District
Health Services

Allergy Health Care Plan

Brandon Valley High School
Ardis Moeller, RN
Fax:605-582-2652
Phone:605-582-3211

Brandon Valley Middle School
Wendy Bunker, RN
Fax:605-582-7206
Phone:605-582-3214

Brandon Valley Intermediate School
Libby Burns, RN
Fax:605-582-6036
Phone:605-582-6035

Brandon Elementary
Jacque Terveer, RN
Logan Smith, RN
Fax: 605-582-2709
Phone:605-582-6315

Fred Assam Elementary
Amanda Larson, RN
Fax:605-582-1505
Phone:605-582-1500

Inspiration Elementary
Amanda Larson, RN
Fax: 605-582-5595
Phone:605-582-8590

Robert Bennis Elementary
Sara Ugland, RN
Fax: 605-582-8012
Phone:605-582-8010

Students Name: _____ Birthdate: ____/____/____ Bus: □ Yes □ No

School: _____ Teacher: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

_____ Phone: _____

Emergency Contact: 1) _____ Phone: _____

2) _____ Phone: _____

Physician: _____ Phone/Fax: _____ /_____

Preferred Hospital: _____

THIS SECTION IS TO BE COMPLETED BY THE PHYSICIAN.

LIST SPECIFIC ALLERGIES:_____

History of Asthma: □ Yes * □ No History of Anaphylaxis: □ Yes * □ No (*higher risk for severe reaction)

Describe History: _____

If Student Has These Symptoms: *Potentially life threatening. The severity of symptoms can change quickly.	**Give Checked Medication or Observation:** (to be determined by the physician authorizing treatment)
Mouth: itching, tingling or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine □ Observation
Skin: Hives, itchy rash, swelling of the face or extremities	□ Epinephrine □ Antihistamine □ Observation
GI: Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine □ Observation
Throat:* tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine □ Observation
Lung:* Shortness of breath, repetitive cough, wheezing	□ Epinephrine □ Antihistamine □ Observation
Heart:* Weak, thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine □ Observation
Other:*	□ Epinephrine □ Antihistamine □ Observation

_____ _____ _____

The following to be determined by the physician authorizing treatment:

EPINEPHRINE TYPE and DOSE:
□ EpiPen Jr. (0.15mg) □ EpiPen (0.3mg)
□ Other: _____

May self-carry medication (for bus ride):
□ **Yes** □ **No**

ANTIHISTAMINE TYPE and DOSE:
□ Benadryl (also known as Diphenhydramine)
□ 12.5mg (1 teaspoon or 1 chewable)
□ 25mg (2 teaspoon or 2 chewable or 1 tab)
□ 50mg (4 teaspoon or 4 chewable or 2 tab)
□ Other Antihistamine: _____

Physician Signature **Date** **Parent Signature** **Date**

parent signature is needed on the back of this form

To administer epinephrine, please follow the step-by-step instructions on the student's epinephrine device and call 911.

- **911 will be activated and student will be transported to hospital. If symptoms have not improved within 10-15 minutes after 1st epinephrine injection, administer a 2nd epinephrine if available.**
- Student epinephrine devices are kept in the nurse's office. If a student is carrying a second set of epinephrine devices in their backpack, please notify the nurse. Emergency medications will be sent on all field trips for elementary and middle school. High school staff will be responsible for carrying student epinephrine on field trips unless the student carries their own.
- **If your child is on a Special Diet for food allergies, please obtain this form from the Brandon Valley School District Child Nutrition Department.**
- *This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part of this form, you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

Please initial:

_____ *The undersigned parent or guardian hereby requests the Brandon Valley School District, through Health Services and /or trained school staff, to administer said child the above described medication and consents to the administration of such medication while on school property or at a school-related event or activity. Parent or guardian is responsible for providing medication directly to school personnel in pharmacy-labeled or original bottle, and is responsible for picking up unused medication. I acknowledge and agree that the school shall secure the medication for the student until administration of the medication is necessary, and that in no circumstances shall the medication be stored in the student's locker.*

_____ ***Epinephrine Auto-Injectors and Inhalers only:*** *I authorize my child to carry & self-administer his/her prescription medication for asthma and/or anaphylaxis while on school property or at a school-related activity or event.* ***Physician order and statement that student is capable of self-administration required.***

Said parent or guardian hereby expressly relieves the Brandon Valley School District, the School Board of the District and all agents of the District from any liability for injury arising from the administration or self-administration of such medication.
I give my permission for the school nurse to discuss with the above named physician observations of effects on my child relating to the above medication, changes in my child as a result of said medication, and any dosage or time changes in medication scheduling. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e. , school nurse, instructors, teacher aides, school administrators, activity supervisors, bus drivers). I authorize the release of any medical or other information necessary to process any Medicaid claims submitted for services received at the Brandon Valley School District. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school; however, any disciplinary action may not limit or restrict the student's immediate access to the medication.
I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse to contact the Primary Care Physician or Allergist if further information is needed.

Parent Signature: _____ Date: _____

Nurse's Signature**: _____ Date: _____**