Placentia Yorba Linda Unified School District
Allergy/Anaphylaxis Action Plan

Name: ______________________ DOB: ______________ Grade: __________

Allergy to: ______________________ School: ______________________

Asthma: ☐ No ☐ Yes (higher risk for a severe reaction). Please provide separate medication form for inhaler if needed

	Give Checked Medication:** **(To be determined by provider authorizing treatment)
Insect Sting: If child has been stung, but *no symptoms*:	☐ **Epinephrine** ☐ **Antihistamine** ☐ NA
Food Allergy: If a food allergen has been ingested, but *no symptoms*:	☐ **Epinephrine** ☐ **Antihistamine** ☐ NA

Symptoms		Action
Any SEVERE SYMPTOMS (After suspected or known contact)**:** **One or more of the following:** LUNG: Short of breath, wheeze, repetitive cough HEART: Pale blue, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips) GUT: Vomiting, diarrhea, cramping pain	➡	1. **INJECT EPINEPHRINE IMMEDIATELY** 2. Call 911 3. Give additional medications:* - Antihistamine - Inhaler (bronchodilator) if asthma 4. Alert parent and school nurse *Antihistamines & Inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE
MILD SYMPTOMS ONLY (After suspected or known contact): MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort **If initialed by Provider, GIVE EPINEPHRINE FOR MILD SYMPTOMS. Initials __________**	➡	1. **GIVE ANTIHISTAMINE** 2. Stay with student 3 Alert parent and school nurse 4. **If symptoms progress (see above). USE EPINEPHRINE**

ALLERGY/ANAPHYLAXIS MEDICATIONS/DOSES

Epinephrine (Brand) ______________________ Side Effects: ______________________ Amount of time between doses: ______________	Dose ____________	Route __________
Antihistamine (Brand) ______________________ Side Effects: ______________________ Amount of time between doses: ______________	Dose ____________	Route __________

It is of my professional opinion that this student should be permitted to carry/self administer this emergency epinephrine. This student has been instructed and demonstrates an understanding of proper usage. *Health Care Provider Initials* ____________	Office Stamp

Authorized Health Care Provider Signature: ______________________ Phone: ____________

Name (printed): ______________________ Date: ______________

(Must include Page 2 and appropriate signatures.)

Placentia Yorba Linda Unified School District
Allergy/Anaphylaxis Action Plan

Parent/Guardian Request for the Administration of Medication: Prescription and Non-Prescription

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

This request is valid for a maximum of one year.

***** Please notify your child's school in writing if your child requires a separate allergen free lunch table.***

I agree with the above Allergy Action Plan: ______________________________ Date: ________________
Parent Signature

Emergency Contact Name/Numbers:

Parent/guardian: ________________________________ Phone: ______________________________

Cell: ______________________________

School Nurse: ________________________________ Phone: ______________________________

Other Emergency Contacts:

Name/Relationship ______________________________ Phone: ______________________________

Name/Relationship ______________________________ Phone: ______________________________

Reviewed by
School Nurse ____ Date ________________

Placentia Yorba Linda Unified School District
Asthma Action Plan

Name_______________________________ **DOB**__________ **School** _____________________**Grade**___

Triggers (check all that apply)**:**
☐ Respiratory infections ☐ Exercise ☐ Pollen ☐ Dust ☐ Mold ☐ Cold air ☐ Weather changes

☐ Animals ☐ Food (list all): ____________________________ ☐ Other: ______________________

Health care provider to complete remainder of this page:

Daily Controller Medicine given at home (Please list): ____

Good Control (if applicable, Peak flow > _______): Breathing is good No cough or wheeze Activity easily tolerated	**Plan:** ▪ Allow activity as tolerated ▪ Use inhaler if needed before exercise/PE, as indicated in orders below
Acute Asthma Attack **If student has any of these Signs or Symptoms:** **(If applicable, Peak flow ____ to _____)** Coughing Wheezing Short of breath, especially with activity Complaints of tightness in chest	**Plan:** ▪ Use inhaler as ordered below ▪ Stay with student / Reassure student ▪ Have student rest in most comfortable position until symptom free ▪ PE limitations: _________________
If symptoms don't improve or worsen	**Plan:** ▪ Notify school nurse and parents ▪ Repeat inhaler as ordered below
Severe/Prolonged Asthma Attack **If student has any of these Signs or Symptoms:** **(If applicable, Peak flow <__________):** Difficulty breathing, coughing, wheezing **with no relief from inhaler** Difficulty walking/talking due to asthma symptoms Turning blue, especially around lips or fingernails Neck/chest pulls in with breathing	**Plan:** ▪ Take inhaler as ordered below ▪ **CALL 911** ▪ Notify school nurse and parent

Inhaler (Brand) __________________________________ Side Effects: ____ Other Instructions: (i.e.: before PE)__________________________ Inhaler should be brought on all field trips or sporting events	Dose _____________ Route_____________ Maximum doses per day: _________________	Amount of time between doses_____________ ---------------------------- **If no relief**, repeat in ______ minutes X ___. ☐ Not applicable

It is of my professional opinion that this student should be permitted to carry/self administer this inhaler. This student has been instructed and demonstrates an understanding of proper usage. *Health Care Provider Initials* _______________	Office Stamp

Authorized Health Care Provider Signature: ___________________________________ Phone: __________________

Name (printed): ___________________________________ Date: ____________________

(Must include Page 2 and appropriate signatures.)

Placentia Yorba Linda Unified School District
Asthma Action Plan

Parent/Guardian Request for the Administration of Medication: Prescription and Non-Prescription

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Medicine must be delivered to school by parent/ guardian or other responsible adult and must be in original, labeled pharmacy container, written in English.

I agree with the above Asthma Action Plan: ______________________________ Date: ________________
Parent Signature

Emergency Contact Name/Numbers:

Parent/guardian: ________________________Phone: ___________________ Cell: __________________

School Nurse: ____________________________________ Phone: ________________________________

Other Emergency Contacts:

Name/Relationship ________________________________ Phone: ________________________________

Name/Relationship ________________________________ Phone: ________________________________

Reviewed by
School Nurse ____ Date ________________

Orange County Department of Education
Community and Student Support Services

5141.31-E
Form 3

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: ____ Birthdate: ___________________

School/District: ______________________________ Teachers Name: ______________________ Grade/Track: ______

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: ____ Date: _________________________

Telephone: (Work) ____ (Home) ______________________

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: ____

Medication: _________________________________ Dose: __________ Route: _____________ Time: _______

If PRN: Amount of time between doses _______________Maximum number of doses

Possible medication reactions: ____

Instructions for emergency care ____

Authorized Health Care Provider Signature: __________________________________

Authorized Health Care Provider Name (print clearly):___________________________

Telephone ____

Provider NPI # ____

Date of Request: ____

Date to Discontinue Medication: ____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _______________

SCHOOL USE:

Reviewed by: ____Date: ______________________________

This request is valid for a maximum of one year.

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

***Name of Student*:** ____________________________

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student’s ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider’s instructions with your child, so that he/she is aware of the time medication is due at school**.**

***This request is valid for a maximum of one year*.**

SEIZURE ACTION PLAN
To be completed by physician

Student Name: **DOB:** **Grade:** **School:**

Seizure Type and description: ____

Routine Medications: ____

Seizure triggers or warning signs: ____

Student's response after a seizure: ____

Date of most recent seizure: ____

EMERGENCY RESPONSE:
A "seizure emergency" for this student is defined as:

☐ Seizure lasting > 5 minutes (seizure type: ________________________________)

☐ Cluster of >_____seizures occurring in 1-hour time period (seizure type: ________________)

☐ Other: ____

TREATMENT PROTOCOL: Select appropriate response for "Seizure Emergency" defined above

☐ Call 911 - No Diastat/Valtoco/Nayzilam protocol

☐ Diastat Administration Protocol

Give ______mg per rectum

☐ Valtoco / Nayzilam (Circle One) Administration Protocol

Give ______mg total dose intranasally: ☐ 1 spray in nostril ☐ 1 spray each nostril of ______ mg

for seizure >_______minutes(seizure type: ________________________________) or

for a cluster of > _______seizures occurring in 1 hour(seizure type: _________________)

- Monitor until parent arrives, student to go home with parent after Diastat is given
- Parents to notify school nurse if Diastat/Valtoco/Nayzilam was given at home
  - Minimum amount of time between doses is __________
  - Maximum number of doses per 24 hours is 2 doses

WHEN TO CALL 911:
- Seizure does not stop within _____minutes of using Diastat/Valtoco/Nayzilam, if prescribed
- Seizure behavior is different from other typical "baseline" episodes
- You are alarmed by the frequency or severity of the seizure
- You are alarmed by the breathing pattern or color changes to lip, face or other area

SPECIAL CONSIDERATIONS AND SAFETY PRECAUTIONS: Select all that apply:

- ☐ None
- ☐ No contact sports
- ☐ No use of power tools/power equipment
- ☐ No activities or climbing above height of head
- ☐ No swimming
- ☐ Swimming with 1:1 adult supervision
- ☐ Wear seizure helmet at all times
- ☐ Helmet with activities on wheels
- ☐ To the student's capabilities, as permitted by parent

Continued on Page 2

SEIZURE ACTION PLAN
To be completed by physician

Does student have a Vagus Nerve Stimulator (VNS)? ☐ NO ☐ YES
If YES, Please complete SPHCS Physician's Order

Does student need additional medications at school? ☐ NO ☐ YES
If YES, Please complete the Authorization for Medication Administration Form

I agree and prescribe the plan as outlined above (or as modified by me) for my patient.

Date: ______________

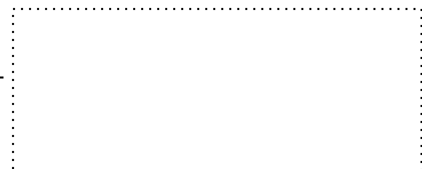
Physician's Signature: ____________________________________

Printed Name: ____

Telephone Number: ____

Provider NPI #: ____

Date to Discontinue Treatment: _______________________________



Office Stamp

I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed herein by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obligated by law to clarify issues associated with this order with the prescribing provider as necessary.

Parent/Guardian Signature: _______________________________________ Date: __________

Telephone: (Cell) ___________________________ (Other) __________________________

School Nurse Signature: ______________________________________Date**:** ________________

5141.31-E
Form 5

Placentia-Yorba Linda Unified School District

SEIZURE DISORDER UPDATE for__________________________ School Year ________

To the parents of __________________________School ________________________ Grade _________

According to school records your child has a history of seizures. The school needs additional information in order to be ready to assist your child as needed. **Please complete and return the following form to the school Health Office.**

1. Parents/Guardians:_____________________ Cell # _________________Home # ________________

   _____________________ Cell # _________________ Home# ________________

2. Type of seizure disorder ___________________________________ Age at onset _________________
3. Frequency of seizures _________________________________ Date of last seizure ________________
4. Medications currently taken for seizures (include dose and time of day given):

   ____

   ____

   ____

5. Signs of an impending seizure ____

   ____

6. Description of seizure pattern and length of seizure (usual time of day, etc)__________________________

   ____

7. Student's reaction to seizures____

   ____

8. Do you feel the seizure disorder is under control with current therapy? yes ______ no ______
9. Physician providing care for seizures _________________________________Phone #________________

Comments ____

____

Unless other specific instructions are provided from the physician, the staff is directed to follow the plan of action indicated below.

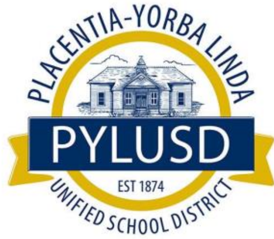
FIRST AID FOR AN EPILEPTIC SEIZURE

1. KEEP CALM. The student is usually not suffering or in danger.
2. Help the student to a safe place but do NOT restrain movements.
3. PLACE STUDENT ON SIDE to prevent choking on vomit or saliva.
4. Loosen tight clothing
5. Do NOT force anything into the mouth or offer anything to drink.
6. Observe the student until fully conscious.
7. Reassure the student and allow time to rest after the seizure.
8. Report the occurrence to an administrator and notify family per instructions in the health file.
9. Most seizures are over in a few minutes.

If the seizure is prolonged or the student stops breathing, call 911-see doctor's orders.

Parent/Guardian signature____ Date ______________

Updated 12/13



Volunteer Training for the Administration of Emergency Naloxone Hydrochloride

Pursuant to California Education Code section 49414.3, volunteers are being sought to administer naloxone hydrochloride to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an opioid overdose in the absence of a school nurse. This emergency opioid antagonist is an FDA approved, pre-dosed, nasally administered spray that works to reduce an opioid overdose.

Volunteers will receive training from a licensed school nurse. Training will include (1) techniques for recognizing symptoms of an opioid overdose; (2) standards and procedures for the storage, restocking and emergency use of naloxone hydrochloride; (3) basic emergency follow-up procedures, including , but not limited to, a requirement for the school administrator, or if the administrator is not available, another school staff member to call 911 and contact pupil's parent or guardian; (4) recommendations on the necessity of instruction and certification in cardiopulmonary resuscitation; and (5) written materials covering the information required under this subdivision. Any employee who volunteers may rescind his or her offer to administer emergency naloxone hydrochloride emergency medication at any time including after receipt of training. No benefit will be granted to or withheld from any employee based on the offer to volunteer and there will be no retaliation against any employee for rescinding the offer to volunteer.

To volunteer to administer emergency naloxone hydrochloride medication, please complete the following:

Employee Name (Print): ____

School: ______________________________ Position: ______________________

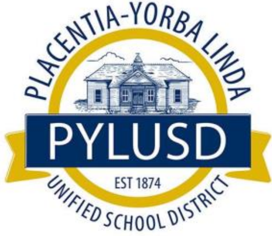
☐ I volunteer to administer emergency naloxone hydrochloride antagonist medication to identified persons.

☐ I understand that I will be trained by a licensed school nurse.

☐ I understand the rescission timeline in the event that I no longer wish to volunteer for this procedure.

Employee Signature: ______________________________ Date: ____________________

Revised 12/2022



Indemnification Agreement for Voluntary Employees Administering Emergency Naloxone Hydrochloride

Pursuant to California Education Code, Section 49414.3 and California Civil Code 1714.22, Placentia-Yorba Linda USD confirms that it will indemnify and defend (Employee Name) ____________________________, hereinafter referred to as "Employee", upon completion of training in the administration of emergency naloxone hydrochloride medication, from any and all civil liability, fees and expenses (including reasonable attorneys' fees), arising out of Employee's acts or omissions in the administering of emergency naloxone hydrochloride, in good faith and not for compensation, to a person who appears to be experiencing an opioid overdose, while the person is in the Placentia-Yorba Linda USD care, custody and control.

_________________________ Employee Name (Print)

_________________________ Authorized District Personnel (Print)

_________________________ Employee Signature

_________________________ Signature of Authorized District Personnel

_________________________ Date

_________________________ Date