Bethel SCHOOLS

Dear Parents,

A law has been enacted in Washington that requires children with life-threatening conditions to have a medication or treatment order on file prior to attending school. This law, called Substitute House Bill 2834, took effect on June 13, 2002.

The medication or treatment order must address the life-threatening condition andit must be on file with the school prior to the child attending school. Under the law,"life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition,our school nurses will be responsible for putting a nursing care plan in place. The law provides that a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to beprovided at school.

Having reviewed the information you provided regarding your child's health, it appears that your child has a life-threatening condition that requires a medication or treatment order.

At the start of every school year you will need new medication order forms filled out byyour health care provider for the next school year to comply with Substitute House Bill2834, commonly known as the "Life Threatening Condition" law. I am enclosing newforms for your convenience.

Included in your packet are:

- Life-Threatening Law Letter
- Healthcare Provider Letter -Please print and hand to Health Care Provider.
- Diet Prescription for Meals at School.
- Health Care Provider Epinephrine Request and Treatment Plan for Anaphylaxis.)This needs to be completed by the health care provider and parent and brought to school before the first day with medication.)

Please have your health care provider complete the **Health Care Provider Epinephrine Request and Treatment Plan for Anaphylaxis** and sign the **Parent Permission**. Return this form to your child's school nurse as soon as possible. Upon receipt of the information from your health care provider, the school nurse will contact you to develop an appropriate nursing plan.

Sincerely,

School Nurse

Dear Health Care Provider,

The state of Washington has published *guidelines for care of students with life-threatening allergies. The guidelines are comprehensive; however, the message to alert health care providers who prescribe emergency medications to be given at school to students who had a contact with an allergen is:

For students with a medical order to administer epinephrine at school to treat anaphylaxis or possible anaphylaxis, the recommended protocol after exposure is to immediately:

1. **Administer Epinephrine**
2. **Call 911**
3. **Call Parents**

Benadryl can no longer be administered first and there cannot be a "wait and watch" period of time. This change is necessary because:

1. Most schools do not have full time nurses in the building. Even if the nurse is in the district, it is impossible for the nurse to be on location at all times to provide an *accurate assessment of the student's health status.*

2. Unlicensed school staff (health clerks, secretaries, principals, teachers, coaches, bus drivers, etc.) will be the front line adults on site when the student has a contact to the specific allergen causing potential anaphylaxis.

3. **Unlicensed school staff members are unprepared to assess the student's health status to determine whether or not to administer epinephrine and/or when to administer it.** ***Registered nurses may not delegate assessment and clinical judgment to unlicensed school staff.***

4. For the safety of the student, epinephrine will be administered immediately as ordered by the health care provider.

Thank you for your assistance in implementing this requirement.

If you have any questions, please contact the school nurse.

**Guidelines for Care of Students with Anaphylaxis* available at http://www.k12.wa.us/HealthServices/Publications/09-0009.aspx

Bethel Public Schools Nutrition Services
Diet Prescription for Meals at School

Student Name: ______________________________ Date of Birth: __________ Age: ____

Name of School: ____ Grade: ______

Section A: To be completed by parent or guardian. Please check box(es) and sign below:

☐ I understand that if my child's medical or health needs change, it is my respons bility to notify my child's school nurse/health clerk and have a new Diet Prescription for Meals at School form completed.

☐ I give Nutrition Services permission to speak with the Physician or Authorized Medical Authority named below to discuss the dietary needs described below.

___________________________________ ____________________ ______________
Parent/Guardian Signature Home Phone Number Date Signed

Section B: To be completed by child's Physician / recognized Medical Authority (if describing a disability).

Does the child have a disability? ☐ Yes ☐ No

If yes, describe the major life activity affected by the disability ________________

____

Does the child have a non-disabling medical condition? ☐ Yes ☐ No

If yes, describe the medical condition ____________________________________

____

Does the child have special nutritional or feeding needs? ☐ Yes ☐ No

If yes, describe the specific need ____

____

If you answered YES to any of the questions above, complete Section C and return to the nurse/health clerk at the child's school.

Section C: PHYSICIAN REQUEST Diet Prescription:
(To be completed by the child's Physician or a recognized Medical Authority).

Note: For any food item to be omitted from diet, a substitute **must** be listed.

Foods to Omit:	Foods to Substitute:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Please attach additional instructions if necessary.

I certify that the student noted above needs special school meals prepared as described above because of the student's disability or chronic medical condition.

____ ______________________
Health Care Provider Signature Date Signed

Name: ____________________________ Office Phone: ______________ Fax:____________
Type or Print

Pierce County Medical Society

HEALTH CARE PROVIDER EPINEPHRINE REQUEST AND TREATMENT PLAN FOR ANAPHYLAXIS

School Year	School	Fax

Student Name: ______________________________ may require treatment to prevent/treat anaphylaxis.

Student is allergic to .

The symptoms of anaphylaxis may include breathing difficulty, facial/throat swelling or tingling, hives, rash, itching, stomach cramps, nausea/vomiting, dizziness, or swelling away from the site of a bee sting.

The treatment plan for preventing/treating anaphylaxis at school is as follows: (check all that apply)

If student is exposed to allergen and/or exhibits any symptom of anaphylaxis,

Give epinephrine IMMEDIATELY:

- ☐ Epinephrine auto-injector 0.3 mg
- ☐ Epinephrine auto-injector 0.15mg

Repeat dose of epinephrine may be given if ____

Call 911 at the time epinephrine is given and notify parent/guardian.

☐ **This student also has asthma and may be at higher risk for developing anaphylaxis.**

Student and parent/guardian have been instructed in use of epinephrine auto-injector. _____ Yes _____ No
Student may carry and self-administer the epinephrine auto-injector ordered above. _____ Yes _____ No

______________________________ Health Care Provider's Signature

______________________________ Health Care Provider's Printed Name or Stamp

______________________ Telephone

______________________ Fax

______________________ Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, (name of child) ____________________________, or allow my child to carry and self-administer as indicated above, the medication prescribed by (name of health care provider) ________________________________ for the ________________school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

______________________________ Parent/Guardian Signature

Work:	Cell:
Home:	Other:

______________________ Date

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above.

School Nurse Signature: Date: