STUDENTS

Health Services – Allergic Reactions

When a student's physician prescribes emergency allergy injections and related medication (Bee Sting Anakit), and there is the possibility that a student might need this treatment during the regular school hours, the following procedures shall be implemented:

1. Three staff members shall be identified to learn the procedure. These three persons shall be trained by a school nurse in the Prince William County Public School system.

2.. The three persons trained shall be regular members of the school staff, which ensures at least one of the three being present during school hours.

3. Any school staff member may, without prejudice, decline to accept responsibility for administering the EpiPen medication to the student.

4. Physician's written prescribed medication authorization form (Attachment I, Section A) and parent/guardian request for administration of medication for allergic reactions (Attachment I, Section B) shall be completed and signed prior to administration of medication by any Prince William County School employee.

5. Self-carrying of prescribed EpiPen requires written consent of a licensed healthcare provider and an Allergy Action Plan completed and on file at the school (Attachments II and III).

6. A copy of the completed Allergy Action Plan and the procedural guidelines to be followed must be filed with the school. The prescription must state:

    a. Name of procedure/medication to be administered.
    b. Statement of dosage for injection.
    c. Specific symptoms for administering medication.

7. All medications shall be stored together in an easily accessible locked area. Parents shall be responsible for ensuring that the medication has not exceeded the expiration date.

8. Any person who, in good faith and without compensation, administers medication to an individual for whom an EpiPen 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.

9. An Allergy Action Plan shall be effective for one school year and must be renewed annually not later than August 1.

The Director of Student Services and the Supervisor of School Health Services are responsible for implementing and monitoring this regulation.

Legal References:

Code of Virginia Sections 8.01-226.5:1 and 22.1-274.2

Attachment I
Section A
Regulation 757-2

PRESCRIBED MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN - *One form per medication

I certify that, in my opinion, it is medically necessary that the medication described below be administered to_____ during school hours and that this medication be administered by school personnel.

Student: _____ DOB: _____ School_____
Reason for medication: _____
Name of medication: _____
Dosage and time: _____
Symptoms for repeating medication: _____
Duration: _____
Date of prescription: _____
Date: _____ Name of physician: _____
(Print)
Signature of physician: _____

Note: Please return this form with medication or have your physician mail or fax it back to your child's school, Attention: School Nurse.

Attachment I
Section B
Regulation 757-2

PARENT/GUARIDAN REQUEST FOR ADMINISTRATION OF MEDICATION FOR ALLERGIC REACTIONS

Student:_____ DOB:_____ School:_____

I/We, _____, agree to furnish the above requested medication in the ORIGINAL sealed container with the label intact. I/We are aware that non-medical personnel may be administering medication to my child. I/We authorize the school nurse to communicate with the physician as allowed by HIPAA**. I/We hereby release the Prince William County School District and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of this request.**

_____ _____
Signature of Parent or Guardian Date

Attachment II
Regulation 757-2

PRINCE WILLIAM COUNTY PUBLIC SCHOOLS
MANASSAS, VIRGINIA 20108

PERMISSION FOR STUDENT TO SELF-CARRY EPIPEN

- I have instructed _____ on the signs and symptoms of his/her allergic reactions that would require reporting to school personnel.

- It is my professional opinion that _____ should carry his/her EpiPen with him/her at all times. (EpiPen shall be kept in school office otherwise.)

_____ _____
Physician/Nurse Practitioner Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal/Designee Signature Date

Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† _____
- If reaction is progressing (several of the above areas affected), give

The severity of symptoms can quickly change. †Potentially life-threatening.

Give Checked Medication**:

**(To be determined by physician authorizing treatment)

☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

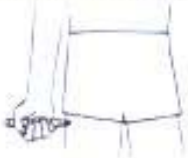
TRAINED STAFF MEMBERS

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.

- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*