Boone County Schools
School Health Services Department
Allergy Health Care Plan
Plan Date: _____________

Student Name: ____________________________________ Date of Birth: __________________________ Grade: _____

Allergic to the following: _____________________________________________________________

Student has Asthma:  [ ] NO  [ ] YES (If yes, higher chance of reaction)

History of Anaphylaxis:  [ ] NO  [ ] YES

Has emergency medical treatment been needed in the last year for allergic reaction?  [ ] NO  [ ] YES

Please mark the signs that are usually present during an allergic reaction

[ ] rash  [ ] lips and/or tongue swelling  [ ] difficulty breathing
[ ] hives  [ ] facial swelling  [ ] nausea/vomiting
[ ] flushed or pale skin  [ ] difficulty swallowing  [ ] loss of consciousness

Other: ____________________________________________________________________________

For Mild Allergic Reaction

What to look for:
If child has had any mild symptoms, monitor child.
Symptoms may include:
- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

What to do:
- Stay with child and:
  - Watch child closely.
  - Give antihistamine (if prescribed).
  - Call parents and child’s doctor.
  - If symptoms of severe allergy/anaphylaxis develop, use epinephrine

For Severe Allergy and Anaphylaxis

What to look for:
If child has ANY of these severe symptoms after eating the food or
having a sting, give epinephrine.
- Shortness of breath, wheezing, or coughing
- Skin: pale or has a bluish color, many hives
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other
  symptoms)
- Feeling of “doom,” confusion, altered consciousness, or
  agitation.

[ ] Special Situation: If this box is checked, child has an
extremely severe allergy. Even if child has mild
symptoms, give epinephrine.

Give epinephrine!

What to do:
1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child’s doctor.
   - Give second dose of epinephrine, if ordered by physician
   - Keep child lying on back.
   - If child vomits/ or has trouble breathing, keep child lying on his/her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of
   epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For School Nurse Use Only

[ ] Stable history  [ ] No ongoing nursing management at school needed
[ ] Potential complications, Hypoxemia  [ ] Standard procedures for reactive airway disease
[ ] High risk factors for ineffective breathing pattern  [ ] Standard school medication procedure
[ ] Other  [ ] Individual HCP

Delegated or assigned caregiver name and date trained __________________________________________
Reviewed Date: __________________________ Nurse Signature: __________________

Revised: Nov. 2018 SLW
Boone County Schools  
School Health Services Department  
Medication Administration Consent Form

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for you use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week’s supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

<table>
<thead>
<tr>
<th>Student’s Name: ___________________________</th>
<th>Date of Birth: ____________</th>
<th>Grade: ________</th>
</tr>
</thead>
</table>

**Allergies:________________________________________________________________________________**

**Please advise the school nurse immediately of any changes in medication or dosing.**

<table>
<thead>
<tr>
<th>Medication 1: ____________________________</th>
<th>Diagnosis/ Condition: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose (mg/ml): ___________________________</td>
<td>Route: ________________________________</td>
</tr>
<tr>
<td>Possible side effects: ______________________</td>
<td></td>
</tr>
</tbody>
</table>

*For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:*

- [ ] may CARRY  - [ ] may SELF-ADMINISTER  - [ ] Physician’s initial in appropriate box
- [ ] may CARRY  - [ ] may SELF-ADMINISTER  - [ ] Parent/ Guardian initial in appropriate box

<table>
<thead>
<tr>
<th>Medication 2: ____________________________</th>
<th>Diagnosis/ Condition: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose (mg/ml): ___________________________</td>
<td>Route: ________________________________</td>
</tr>
<tr>
<td>Possible side effects: ______________________</td>
<td></td>
</tr>
</tbody>
</table>

*For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:*

- [ ] may CARRY  - [ ] may SELF-ADMINISTER  - [ ] Physician’s initial in appropriate box
- [ ] may CARRY  - [ ] may SELF-ADMINISTER  - [ ] Parent/ Guardian initial in appropriate box

Specific to field trips: In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on a field trip. I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools’ Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the “District”) from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child’s physician.

Trained Unlicensed School Personnel: The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administrating the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student’s physician in the case of a life threatening emergency where in immediate intervention is required.

Parent/ Guardian signature: ___________________________ Date: ______________________

Physician signature: ___________________________ Date: ______________________

Physician name: ___________________________ Phone number: ______________________

**Staff administering medication are trained annually by a registered nurse.**

Revised: Nov. 2018 SLW
Boone County Schools  
School Health Services Department  
Food Allergy Cafeteria Information  

Student Name: __________________________________________  Date of Birth: ____________________

Teacher Name: __________________________________________  Grade: _________________________

Food Allergies:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(example) Peanut</td>
<td>X</td>
<td></td>
<td>hives, trouble breathing</td>
</tr>
</tbody>
</table>

Does this student need to sit at an allergy table at lunch?  □ YES  □ NO

Can the student be around the allergen (air born reaction- this is used for classroom parties)? □ YES  □ NO

Parent Signature: __________________________________________  Date: ____________________

Revised: Nov. 2018 SLW
# Eating and Feeding Evaluation: Children with Special Needs

## Part A

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School:</td>
<td>Grade:</td>
</tr>
<tr>
<td>Class:</td>
<td></td>
</tr>
</tbody>
</table>

### Does the child have a disability? If yes, describe the major life activities affected by the disability

- [ ] Yes
- [ ] No

### Does the child have special nutritional or feeding needs? If yes, complete **Part B** of this form and have it signed by a licensed physician.

- [ ] Yes
- [ ] No

### If the child is not disable, does the child have special nutritional or feeding needs? If yes, complete **Part B** of this form and have it signed by a recognized medical authority.

- [ ] Yes
- [ ] No

---

*If the child does not require special meals, the parent can sign at the bottom and return the form to school food services*

## Part B

### List and dietary restrictions:

- 

### List any allergies or food intolerances to avoid:

- 

### List foods to be substituted:

- 

### List foods that need the following change in texture. If all foods need to be prepared in the manner, indicate “ALL”.

- **Cut up or chopped into bite sized pieces:**

- **Finely ground:**

- **Pureed:**

- 

### List any special equipment or utensils that are needed:

- 

### Indicate any other comments about the child’s eating or feeding patterns:

- 

### Parent’s Signature: ___________________________  Date: ___________________________

### Physician’s or Medical Authority’s Signature: ___________________________  Date: ___________________________

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*Revised: Nov. 2018 SLW*
Boone County Schools
Student Services Division
School Health Services Department
Transportation/Student Health Concerns

School Year: ____________________________

Student Name: _______________________________________________________

Address: __________________________________________________________________

Bus Number: _________   School:  __________________________________________

Date of Birth:  __________________   Age:  ________________    Grade:  _________

Health Concern of student: ________________________________________________

Medication/supplies which will be with student during bus transportation:

__________________________________________________________________________

Is student responsible for medication administration?  Yes [ ]   No [ ]

Comments: ______________________________________________________________

Emergency care to be given to student by bus driver: ____________________________

__________________________________________________________________________

Parent / guardian signature: _______________________________________________

Daytime phone number: ____________________________________________________

Date: ____________________________

This completed form must be returned to your child’s school office in order for
transportation to be notified.

School nurse is to scan completed form to Transportation: cynthia.buttery@boone.kyschools.us

Revised: Nov. 2018 SLW