Chesterfield County Public Schools
Student Health Service

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools (CCPS)**.** The health information provided for your child indicates that he/she has a health concern. To adequately meet your child's health needs while in school, please do the following as soon as possible:

1. Have your licensed healthcare provider (physician, physician's assistant or nurse practitioner) complete and sign the attached Individualized Healthcare Plan (IHP). IHPs are also available online at http://mychesterfieldschools.com/parents/student-health-and-safety/.
2. Provide your signature on the IHP.
3. Return the completed plan to the attention of the school nurse at the school your child will be or is attending.

It may be necessary for some students to carry and self-administer emergency medication. This requires proper documentation by a licensed healthcare provider on the appropriate health plan. Permission for a student to possess and self-administer medication (for example auto-injectable epinephrine or medication to manage asthma or diabetes) is effective for one school year and must be renewed annually. Please consult with your school nurse for details.

If medication is needed for your child, complete the CCPS School Medication Record form required for all medications that students take during the school day. This form is available in the school clinic and at http://mychesterfieldschools.com/parents/student-health-and-safety/**. Medication must be provided by the parent/guardian and brought to school by the parent/guardian in the original appropriately labeled container. See the CCPS website for details regarding the medication policy and regulation (4130 and 4130R).**

For students with a life-threatening food allergy, the Food Allergy Medical Statement must be completed by a physician, physician's assistant or nurse practitioner if the child needs any of the following: to be identified by cafeteria staff as having a life-threatening allergy; if child is lactose intolerant; if substitutions or food modifications need to be made in the school breakfast or lunch programs. The Cafeteria Manager at school must also be notified. For assistance you may contact the Nutritionist, CCPS Food & Nutrition Department, at (804) 743-3717.

A health condition may be considered a disability. If you suspect your child may have a disability, ask your child's teacher, Counselor, school nurse or administrator for a referral to consider eligibility for 504 or special education services.

If you have any questions, call the registered nurse at your child's school. We appreciate your prompt attention to this matter. Thank you for partnering with us to support your child's well-being in school.

Sincerely,

1st notice _____

2nd notice _____

Attachment

Chesterfield County Public Schools
Student Health Services

Revised 7/2016

Healthcare Plan effective for the current school year, including summer school.

Chesterfield County Public Schools
Student Health Services

INDIVIDUALIZED HEALTHCARE PLAN

ANAPHYLAXIS/LIFE-THREATENING ALLERGIC REACTION

Section 1 – **To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner).**

STUDENT NAME:	**Date of Birth:**
Grade:	**School:**

ALLERGY HISTORY

Student has a life-threatening allergy to: ☐ Food ☐ Latex ☐ Insect ☐ Other, specify:_____

Symptoms occur due to: ☐ Ingestion ☐ Inhalation ☐ Touch/skin contact ☐ Injection/sting ☐ Unknown

- **Please list food allergens:** _____
- Student can have food provided **only** by parent/guardian. ☐ Yes ☐ No
- Student knows what food items to avoid. ☐ Yes ☐ No
- Does student require specialized eating location? ☐ Yes ☐ No

Has this child ever had an anaphylactic reaction: ☐ Yes ☐ No

Please indicate approximate date of last reaction: _____

Does student recognize signs/symptoms of allergic reaction? ☐ Yes ☐ No

Does student have asthma? (increased risk factor for severe reaction) ☐ Yes ☐ No

TREATMENT PLAN

To Licensed Healthcare Provider: This is the standard emergency plan for responding to anaphylaxis provided by Chesterfield County Public Schools. ***Please review*.**

COMMON SYMPTOMS ASSOCIATED WITH ANAPHYLAXIS:	
• Swelling of the lips, tongue, throat or face	• Coughing, sneezing, hoarseness, nasal congestion
• Hives; generalized flushing and itching of the skin	• Difficulty swallowing, nausea, vomiting, abdominal cramping
• Difficulty breathing, wheezing, chest tightness	• Tingling sensation or warmth, metallic taste in mouth
	• Dizziness, faintness, feeling of apprehension, "feeling funny"

If student develops symptoms as a result of exposure to a known or suspected allergen(s):

- Administer epinephrine auto-injector: (check one) ☐ EpiPen® ☐ Auvi-Q® ☐ Adrenaclick® ☐ Generic Epinephrine Injection
  Dosage: 0.3 mg IM (child weighs > 66 lbs) **OR** 0.15 mg IM (child weighs < 66 lbs)
  Frequency: Repeat epinephrine dose 5 - 15 minutes after the first injection, if symptoms persist or return.
- **Call 911.** Advise EMS anaphylaxis is suspected and epinephrine has been given.
- Keep student lying down or seated.
- Notify parent if not already contacted.
- Remain with student and observe for difficulty breathing until EMS personnel arrive.
- Start CPR if breathing or heart stops.

Are you in agreement with the above plan? ☐ Yes ☐ No

If no, please provide specific instructions **including additional medication orders**:

_____

_____

Unless documented by a Licensed Healthcare Provider, emergency medication is kept in the school clinic per Chesterfield County Public School Policy 4130, Administration of Medication to Students. Please complete the information below if the student's emergency medication will **NOT** be kept in the school clinic.

1. Does this student's epinephrine auto-injector need to be with the student at all times? ☐ Yes ☐ No
2. Does this student's epinephrine auto-injector need to be on the bus? ☐ Yes ☐ No
3. If yes to question 1, can the student physically carry the medicine? ☐ Yes ☐ No
   If no, the medicine will be kept with a supervising adult.
4. Is this student able to self-administer his/her epinephrine auto-injector? ☐ Yes ☐ No
   Checking yes verifies that student has demonstrated the ability to safely and effectively self-administer epinephrine auto-injector.

Licensed Healthcare Provider Printed Name/Signature:		
Date:	**Telephone #**	**Fax #**

HEALTH PLAN

ANAPHYLAXIS/LIFE-THREATENING ALLERGIC REACTION

STUDENT NAME: _____ DOB: _____

Section 2 – To be completed by Parent/Guardian.

Parent/Guardian, please review the following and sign below:

- I understand school staff and/or the school health nurse may communicate with the Licensed Healthcare Provider/medical office staff about this health plan.
- I understand I am responsible for providing the school with all medication for my child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students.*
- I understand I am responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
- I understand snacks and supplies I provide will be administered as ordered by the Licensed Healthcare Provider.
- **I agree to this health plan for my child.**

_____

Parent/Guardian Signature **Print Name** **Date** **Phone Number**

_____

School Nurse Name/Signature **Date Received** **Date Emergency Action Plan Distributed**