VENTURA UNIFIED SCHOOL DISTRICT
Health Programs/Services

SPECIALIZED PHYSICAL HEALTH CARE (SPHC) SERVICE- ANAPHYLAXIS MANAGEMENT

Parent/Guardian Request and Physician Authorization -- (complete each school year)

Valid for current school year ____-____

Date _____ School _____ Grade _____

Name of Student _____ Date of Birth _____
Last First Middle Initial

Dear Parent/Guardian:

1. **Part 1: Parent/Guardian Request** for Specialized Physical Health Care (SPHC) Service must be completed annually when treatment with epinephrine is warranted during school hours.
2. **Part 2: Physician Authorization** must be completed by a physician. **A new Physician Authorization must be received in order to modify health care during a school year.**
3. Specialized physical health care service(s) **will not** be performed at school until both **Part 1** and **Part 2** are completed and returned to the school nurse.
4. In order to provide a safe school environment for your child, the school nurse will train designated school personnel in administration of emergency epinephrine after reviewing the specialized physical health care protocol authorization.

Return both Part 1 and Part 2 to the school nurse. Your prompt response is appreciated.

Part 1: Parent/Guardian request/consent for SPHC Service: California Education Code 49423.5 allows specialized physical health care services to be performed by designated school personnel under training/supervision of the School Nurse.

I, the undersigned, as the parent/guardian of the above student, request that Specialized Physical Health Care Service for Anaphylaxis Management be provided for my child. I give permission for the school nurse to contact the physician authorizing these services for my child. I understand the school nurse may initiate a Student Agreement to support my child's ability to self-manage epinephrine administration as authorized by the physician.

As parent/guardian, **I will….**

1. Provide and maintain all necessary materials, equipment, and supplies.
2. Provide medication as prescribed for school use, including a 3-day supply for disaster preparedness.
3. Update the school nurse within 24 hours of any change in my child's health status, medication, or treatment regimen.
4. Provide emergency phone numbers of parent/guardian and physician for use in case of an anaphylaxis related question and/or during an emergency situation.

Signature Parent/Guardian _____ Phone_____ Date _____

Return this form with attached Physician's Authorization to site School Nurse/Health Office

ATENCIÓN ESPECIALIZADA DE SALUD FÍSICA (SPHC)
MANEJO DE LA ANAFILAXIA
Solicitud del padre/madre o tutor y autorización del médico -- (completada cada año)

Válida para el año escolar actual _____-_____

Fecha _____ Escuela _____ Grado _____

Nombre del alumno(a) _____ Fecha de nacimiento _____
Apellido Nombre Inicial del segundo nombre

Estimado padre/madre o tutor:

5. **Parte 1: La solicitud del padre/madre o tutor** para la atención especializada de salud física (SPHC, siglas en inglés) debe completarse anualmente cuando se requiere el tratamiento con epinefrina durante las horas de clases.
6. **Parte 2: La autorización del médico** debe ser completada por un médico. **Una nueva autorización del médico debe ser recibida con el fin de modificar la atención de salud durante el año escolar.**
7. **No** se brindaran servicios de atención especializada de salud física hasta que no se hayan completado y devuelto la **Parte 1** y **Parte 2** a la enfermera de la escuela.
8. Con el fin de proporcionar un ambiente escolar seguro para su hijo, la enfermera de la escuela capacitará a personal designado de la escuela en la administración de epinefrina de emergencia después de revisar la autorización del protocolo de atención especializada de salud física.

Devolver la Parte 1 y Parte 2 a la enfermera de la escuela. Le agradeceremos su pronta respuesta.

Parte 1: Petición o consentimiento del padre/madre o tutor para el servicio SPHC: El Código de Educación de California 49423.5 permite que los servicios de atención especializada de salud física sean proporcionados por el personal escolar designado en virtud de capacitación o supervisión de la enfermera de la escuela.

Yo, el abajo firmante, como padre/madre o tutor del estudiante mencionado, solicito que se proporcione a mi hijo el servicio de atención especializada de salud física para el manejo de la anafilaxia. Doy permiso para que la enfermera de la escuela se ponga en contacto con el médico que autoriza estos servicios para mi hijo. Entiendo que la enfermera de la escuela puede iniciar un acuerdo estudiantil para apoyar la capacidad de mi hijo para manejar por sí mismo la administración de epinefrina según es autorizado por el médico.

Como padre/madre o tutor **Yo....**

5. Proporcionaré y mantendré los materiales, equipo y suministros necesarios.
6. Proporcionaré medicación según lo prescrito para el uso escolar, incluyendo un suministro de 3 días para la preparación para desastres.
7. Avisaré a la enfermera de la escuela de cualquier cambio en el estado de salud, medicamentos o régimen de tratamiento de mi hijo dentro del plazo de 24 horas.
8. Proporcionaré números telefónicos de emergencia del padre/madre o tutor y del médico para su uso en caso de alguna pregunta relacionada con la anafilaxia o durante una situación de emergencia.

Firma del padre/madre o tutor_____ Teléfono_____ Fecha _____

Envíe este formulario con la autorización del médico adjunta a la enfermera de la escuela u oficina de salud

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SPECIALIZED PHYSICAL HEALTH CARE (SPHC) SERVICE- ANAPHYLAXIS MANAGEMENT

Please sign, stamp, and date after June 20

Part 2: Physician Authorization for SPHC Service **Valid for current school year ___ - ___**

Date _____ School _____ Grade _____

Name of Student _____ Date of Birth _____
Last First Middle Initial

Dear Physician:
Please respond to the items outlined below. Check applicable boxes, complete requested information, review standard care, modify as necessary, and indicate accommodations for this student's anaphylaxis care at school. The school nurse will provide training and supervision of unlicensed assistive personnel for the Specialized Physical Health Care Services indicated. The parent/guardian is responsible to provide the school site all necessary medication and equipment.

Complete this form only when EPINEPHRINE treatment is being authorized during school hours. A new Physician Authorization must be received annually or when there is a change in anaphylaxis care at school.

_____R.N., School Nurse Phone: _____

1. **Medical Diagnosis:**
_____

2. **Known Trigger(s) or Allergen(s):** ❑ insect sting ❑ peanut ❑ tree nut (specify) _____ ❑ dairy ❑ soy ❑ egg ❑ latex ❑ shellfish (type) _____ ❑ unknown ❑ other

3. **Type of Known Allergic Reaction:** ❑ local ❑ systemic ❑ other _____

4. **Antihistamine Administration:** Name of medicine _____

Dosage: ❑ 12.5 mg ❑ 25 mg ❑ 50 mg ❑ other _____ mg

When to administer antihistamine (check one): ❑ Give immediately upon known exposure to allergen

❑ Give if symptoms occur

5. **Epinephrine Administration:** ❑ EPIPEN or ❑ Auvi Q or ❑ generic ❑ JR. strength 0.15mg or ❑ Adult strength 0.3mg

Level of self-management: ❑ adult-administered ❑ self-administered

Equipment: ❑ Epinephrine stored class/health office ❑ student to carry Epinephrine

❑ other _____

Name of Student _____ DOB_____ School _____

When to administer Epinephrine at school (check one box only):

- ❑ **Give upon observation of systemic reaction. Common reactions:**
  - ✓ **Mouth: Itching, tingling, or swelling of lips, tongue, mouth**
  - ✓ **Skin: Itching or burning, hives, rash, swelling of face or extremities, flushing**
  - ✓ **Stomach: Nausea, abdominal cramps, vomiting, diarrhea**
  - ✓ **Throat: Tightening of throat, hoarseness, and/or hacking, repetitive cough**
  - ✓ **Lung: Shortness of breath, wheezing, chest pain/tightness**
  - ✓ **Heart: Weak or thready pulse, low blood pressure, paleness, blueness, general body weakness, dizziness, fainting/unconsciousness**
  - ✓ **Other: Localized or general body swelling, apprehension, red/itchy/watery eyes, excessive sneezing, nasal congestion**

OR

- ❑ **Give immediately, upon known exposure to allergen**

If symptoms occur, call 911, notify parent, school nurse, and school administrator

Physician Modification(s): _____

I, the undersigned, recommend the Specialized Physical Health Care Services as indicated.

Print or **use STAMP** for Physician Name Address Phone	Physician Signature _____ Date _____

Return Part 1 and Part 2 to the site School Nurse/Health Office

School Nurse has reviewed the completed protocol:

***Signature*_____ *Date:*_____

Original of this order kept in site Health Record

HD:sphc: (8/2/01pc) Revised (6/24/04pc, 6/3/08, 9/4/12, 5/28/13, 10/7/15)