



**Clark County School District Health Services
LICENSED HEALTH CARE PROVIDER'S SPECIALIZED ORDERS
FOR HEALTH SERVICES AT SCHOOL: Anaphylaxis**

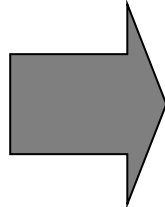
1. Student Name: _____ ID #: _____ Date of Birth: _____ Weight: _____
2. Allergic to: _____
3. Reaction to Allergen: _____
4. No epinephrine ordered.
5. **Autoinjector epinephrine** (dose): 0.15 mg IM 0.3 mg IM
6. **Nasal spray epinephrine** (dose): Neffy® 1 mg intranasal (33-66 lbs.) Neffy® 2 mg intranasal (66 lbs. and above)
7. May repeat epinephrine administration in 5 minutes if no relief is seen from the first administration. May give student's second epinephrine dose, if available, or stock epinephrine injection if a second dose is not available, even if the first administration was nasal Neffy®.
8. Antihistamine: _____ (_____ mg) by mouth one time only at school. Antihistamine is given for mild symptoms only. **If antihistamine is given, the student must go home.**
9. Special Diet Needed for Food Allergies: No Yes (If yes, parent must complete CCSD special diet request form)
 - a. Diet order (what foods to avoid): _____
 - b. For dairy allergy, select: No milk to drink No dairy products at all Provide soy milk
 - c. If texture modification is needed, select: ¼ inch chopped ½ inch chopped Ground Pureed

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

Lung: Difficulty breathing, shortness of breath, wheezing, repetitive cough, chest tightness
Heart: Pale, blue, faint, weak pulse, dizzy, confused, low blood pressure
Throat: Tight, hoarseness, difficulty swallowing
Mouth: Swelling of the tongue and/or lips
Skin: Many hives over body
Eyes/Nose: Runny nose, congestion, sneezing, watery/itchy/swollen eyes

Or **combination** of symptoms from different body areas

Mouth: Itchy mouth
Skin: Hives, itchy rashes, swelling of eyes and lips
Gut: Vomiting, cramping, pain, diarrhea



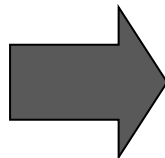
- ADMINISTER EPINEPHRINE IMMEDIATELY
- Call 911
 - Additional medications, if ordered:
 - Antihistamine
 - Inhaler (bronchodilator)

Inhalers/bronchodilators and antihistamines are NOT to be depended upon to treat a severe reaction (anaphylaxis), use epinephrine.

****When in doubt, use epinephrine. Symptoms can rapidly become more severe.****

MILD SYMPTOMS ONLY:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort



GIVE ANTIHISTAMINE
 Stay with child, alert parents to take child home.

IF SYMPTOMS PROGRESS (see above), ADMINISTER EPINEPHRINE

Provider Name (Print) _____ Provider Signature _____ NPI Number _____ Date _____
 Stamped LHCP Signature is not accepted

Address _____ Fax # _____ Phone # _____

Provider & Parent/Guardian Must Complete this Form Yearly.



Student Name: _____ ID # _____ Date of Birth: _____

PARENT/GUARDIAN REQUEST FOR HEALTH SERVICES IN SCHOOL

1. This procedure is necessary for my child to attend school and cannot be provided before or after school hours.
2. I request that the treatment be administered in accordance with the above licensed health care provider's orders. I will notify the school if the health status of my child changes, the licensed health care provider changes, or the procedure is changed or canceled.
3. I agree to provide clearly labeled, functional equipment and supplies. I also agree to provide verbal or written directions for use.
4. The school is authorized to secure emergency medical services for my child whenever the need for such services as deemed necessary.
5. Parent/Guardian needs to complete a Medical Statement to Request a Special Diet (FSD-F5) form if ordered unless student brings meals from home.
6. The school nurse may perform weight measurement as needed for dosage purposes.
7. The Clark County School District has advised me that my child's Licensed Health Care Provider may have prescribed a treatment regimen that may not have been studied or approved for use in children under 18 years of age. Nevertheless, I hereby direct the Clark County School District to provide such medical treatment to my child in accordance with the recommendations of my child's Licensed Health Care Provider and hereby agree to hold the Clark County School District, its Board of School Trustees, the school and its employees harmless from any liability for any injury, including the death of my child, that may result from following the Licensed Health Care Provider's orders concerning the treatment regimen prescribed for my child.

Notice: Pursuant to NAC 632.220, as a condition of providing care for the purposes related to this form, a registered nurse may need to contact the licensed health care provider or associates regarding the verification of an order given for the care of a patient to ensure that it is appropriate and properly authorized and that there are no documented contraindications in carrying out the order.

Parent/Guardian Name (Print) Parent/Guardian Signature Date

Name of Procedure: **Anaphylaxis** Date of Order: _____

Reviewed by School Nurse:

School Nurse Name (Print) School Nurse Signature Date

Provider & Parent/Guardian Must Complete this Form Yearly.