School: _____ HS-166
3/23

Clark County School District Health Services

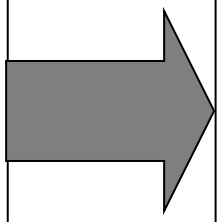
LICENSED HEALTH CARE PROVIDER'S SPECIALIZED ORDERS FOR HEALTH SERVICES AT SCHOOL: Anaphylaxis

1. Student Name: _____ ID #: _____ Date of Birth: _____ Weight: _____
2. Allergic to: _____
3. Reaction to Allergen: _____
4. ☐ No epinephrine ordered.
5. ☐ Order for epinephrine auto injector (select dose): ☐ 0.15 mg IM ☐ 0.3 mg IM
6. May repeat epinephrine injection in 5 minutes if no relief is seen from first injection and if 2nd epinephrine injection is available at school
7. ☐ 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.**
8. Special Diet Needed for Food Allergies: ☐ No ☐ Yes (Parent may complete CCSD special diet request form)
   a. Diet order (what foods to avoid): _____
   b. For dairy allergy, check appropriate choice(s): ☐ No milk to drink ☐ No dairy products at all (including milk, cheese, yogurt and food containing dairy) ☐ Provide soy milk
   c. If texture modification is needed, select **one** option: ☐ ¼ inch chopped ☐ ½ inch chopped ☐ Ground ☐ Pureed

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing or swallowing
Mouth: Obstructive swelling (tongue)
Skin: Many hives over body

Or **combination** of symptoms from different body areas
Skin: Hives, itchy rashes, swelling, (e.g., eyes, lips)
Gut: Vomiting, cramping pain



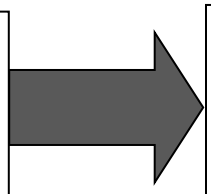
- **INJECT EPINEPHRINE IMMEDIATELY**
- **Call 911**
- Additional medications: if ordered
- Antihistamine
- Inhaler (bronchodilator)

***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), INJECT EPINEPHRINE

Provider Name (Print) | **Provider Signature** (Stamped signatures not accepted) | Date

Address | Fax | Phone

Provider & Parent/Guardian Must Complete this Form Yearly.

CLARK COUNTY SCHOOL NURSES

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.

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: _____

Provider & Parent/Guardian Must Complete this Form Yearly.