SEVERE ALLERGY REACTION PLAN & MEDICATION ORDERS

Place student picture here

Student has severe allergy to:

Nurse's name/phone:

NAME: **Birthdate:**

Grade: **School:** ☐ Bus # ☐ **Walk** ☐ **Drive**

Allergy History: ☐ **History of anaphylaxis/severe reaction** ☐**Skin testing indicates allergy** **Date of Last Reaction:**

Other Allergies: ☐ **Student has Asthma** (increased risk factor for severe reaction)

Epinephrine auto-injector (**EAI**) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER: _____

Inhaler(s) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER: _____

Anaphylaxis (Severe allergic reaction) is an excessive reaction by the body to combat a foreign substance that has been eaten, injected, inhaled or absorbed through the skin. It is an intense and life- threatening medical emergency. **Do not hesitate to give Epinephrine and call 911.**

USUAL SYMPTOMS of an allergic reaction:

MOUTH--Itching, tingling, or swelling of the lips, tongue, or mouth

THROAT--Sense of tightness in the throat, hoarseness and hacking cough

LUNG--Shortness of breath, repetitive coughing, and/or wheezing

GENERAL--Panic, sudden fatigue, chills, fear of impending doom

SKIN--Hives, itchy rash, and/or swelling about the face or extremities

GUT--Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea

HEART --"Thready" pulse, "passing out", fainting, blueness, pale

This Section To Be Completed By A Licensed Healthcare Provider (LHP):

If a student has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to something allergic to):

1. Give Epinephrine Auto Injector (EAI) ☐ 0.3 mg ☐ Jr. 0.15 mg

   ☐ **May repeat Epinephrine (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived. Document time medications were given below and alert EMS when they arrive.**

   _____ _____ _____ _____

   EAI #1 EAI #2 Antihistamine Inhaler

2. **Stay with student.**
3. **CALL 911 – Advise EMS that student has been given Epinephrine**
4. **Notify parents and school nurse.**
5. ***After*** **Epinephrine given, give Benadryl® or antihistamine _____ (ml/mg/cc)**
6. **If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction,**

   After Epinephrine and antihistamine, may give:

   ☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)

   ☐ Levalbuterol 2 puffs (Xopenex®) ☐ Other_____

7. **A student given Epinephrine must be monitored by medical personnel or a parent and may NOT remain at school.**

SIDE EFFECTS of medication(s):

Epinephrine: **increased heart rate**, _____ **Antihistamine**: **sleepy** _____

Albuterol/Levalbuterol: **increased heart rate, shakiness,** _____

☐ Student may carry & self-administer Epinephrine +/or antihistamine ☐ Student has demonstrated Epinephrine auto-injector use in LHP's office

☐ Student may carry & self-administer Inhaler ☐ Student has demonstrated inhaler use LHP's office

PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY

Disability: Potential anaphylaxis if food ingested. **Major life activity affected:** Potential shut down of multiple body symptoms leading to death.

How disability restricts student diet: Student must not eat food containing allergen

☐ **Check here if student will EAT school provided meals during the entire school year. If so, one of the following must be completed.**

1. **Foods to omit:** _____

   Suggested general substitutions: _____

2. ☐ **Check here if standard substitutions offered in our district are acceptable.**
   (Contact district Food Services Manager for details.) **Note: Meals from home provide the safest food option at school.**

LHP Signature:		Providers Printed Name:
Start date:	End date ☐ Last day of school ☐ Other: _____	
Date:	Telephone #:	Fax #:

Student: _____

Care Plan for Severe Allergy – Part 2 – Parent

Brief Medical History_____

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
- Parent/guardian should be notified of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- Student is responsible for making his/her own food decisions. ☐ Yes ☐ No
- When eating student requires: ☐ Specified eating location. Where? _____
  ☐ No restrictions

Bus Concerns –Transportation should be alerted to student's allergy.

- This student carries Epinephrine auto-injector (**EAI**) on the bus? ☐ Yes ☐ No
- EAI can be found in ☐ Backpack ☐ Waist pack ☐ On Person ☐ Other (specify) _____
- Student will sit at front of the bus? ☐ Yes ☐ No

Field Trip Procedures – Epinephrine auto-injector must accompany student during any off campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip? ☐ Yes ☐ No
- Staff members on trip must be trained regarding Epinephrine auto-injector use and this health care plan (plan must be taken).

I wish to meet with the building 504 team to discuss additional accommodations ☐ Yes ☐ No

EMERGENCY CONTACTS

Mother/Guardian		Father/Guardian	
	Name		Name
	Home Phone		Home Phone
	Work Phone		Work Phone
	Other		Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

My student may carry and is trained to self-administer his/her own Epinephrine: ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No
My student may carry and use his/her asthma inhaler ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHP/medical office staff about this plan and medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and monitored school staff.
- I release school staff from any liability in the administration of this medication at school.
- I understand this is a life threatening plan and can only be discontinued, in writing, by the prescribing LHP.
- Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHP.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No
- This permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer.

Parent/Guardian Signature **Date**

School Nurse Reviewed **Date**

For School Registered Nurse's Use Only

Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication

Device(s) if any, used Expiration date(s):

Registered Nurse Signature **Date**

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members involved with the student.