

SEVERE ALLERGIC REACTION PLAN & MEDICATION ORDERS

Place
student
picture
here

Student has severe allergy to: _____

Nurse's name/phone: _____ Date Plan Developed/Reviewed: _____

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)

Epi auto-injector(s) 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 Epi auto-injector -and call 911.**

USUAL SYMPTOMS of an allergic reaction:

- | | |
|--|--|
| MOUTH--Itching, tingling, or swelling of the lips, tongue, or mouth | SKIN--Hives, itchy rash, and/or swelling about the face or extremities |
| THROAT--Sense of tightness in the throat, hoarseness and hacking cough | GUT--Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea |
| LUNG--Shortness of breath, repetitive coughing, and/or wheezing | HEART --"Thready" pulse, "passing out", fainting, blueness, pale |
| GENERAL--Panic, sudden fatigue, chills, fear of impending doom | |

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 Epi auto-injector 0.3 mg Jr. 0.15 mg
 May repeat Epi auto-injector (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.

Epi-pen #1 _____	Epi-pen #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 Epi auto-injection 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 Epi auto-injection and antihistamine, may give:

<input type="checkbox"/> Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®)	<input type="checkbox"/> Albuterol/Levalbuterol unit dose SVN (per nebulizer)
<input type="checkbox"/> Levalbuterol 2 puffs (Xopenex®)	<input type="checkbox"/> Other: _____
7. A Student given an Epi auto-injector must be monitored by medical personnel or a parent & may NOT remain at school.

SIDE EFFECTS of medication(s):

Epi auto-injector: increased heart rate, _____ Antihistamine: sleepy, _____

Albuterol/Levalbuterol: increased heart rate, shakiness, _____

- | | |
|---|---|
| <input type="checkbox"/> Student may carry & self-administer Epi auto-injector +/- or antihistamine | <input type="checkbox"/> Student has demonstrated Epi auto-injector use in LHP's office |
| <input type="checkbox"/> Student may carry & self-administer Inhaler | <input type="checkbox"/> Student has demonstrated inhaler use LHP's office |

PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY – (required by USDA Food Guidelines)

Check here if you will be submitting a food substitution form. (A separate food substitution form must be filled out by your health care provider if you are requesting the Food Services department at your child's school to make substitutions for your child.)

Foods to omit: _____

General substitutions: _____

(Contact district Food Services Manager for details) **Note: Meals from home provide the safest food option at school.**

LHP Signature: _____		LHP Print Name: _____	
Start date: _____	End date <input type="checkbox"/> Last day of school <input type="checkbox"/> 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
- Other (specify) _____

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

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

Field Trip Procedures – Epi 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 Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify): _____

EMERGENCY CONTACTS

Mother/Guardian	Name	Father/Guardian	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 Epi auto-injector:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide extra for office?	<input type="checkbox"/> Yes <input type="checkbox"/> No
My student may carry and use his/her asthma inhaler:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide extra for office?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 supervised 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

For District 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	Expiration date(s):
Device(s) if any, used	
School Nurse Signature	Date