Student Picture

SEVERE ALLERGIC REACTION PLAN & MEDICATION ORDERS/504

Date Plan Created:_____ **Date Plan Revised:**_____**Allergy Notification Card Made?** ☐ **Signature**_____

Student has severe allergy to:

NAME:		**Birthdate:**	☐ Student has asthma
Grade:	**School:**	☐ **Bus #**	☐ **Walk** ☐ **Drive**

Allergy History: ☐History of anaphylaxis/severe reaction ☐ **Skin testing indicates allergy** **Date of last 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 EAI 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
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 EAI (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 administered Epinephrine**

4. **Notify parents and school nurse.**

5. **After EAI administered, administer Benadryl® or antihistamine** _____ **(ml/mg)**

6. **If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction,** After EAI and antihistamine, may administer:

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

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

☐ Student may carry & self-administer EAI +/or antihistamine ☐ Student has demonstrated EAI 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.

FOODS TO OMIT:_____

Suggested general substitutions:_____

Note: Meals from home provide the safest food option at school.

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

Care Plan for Severe Allergy – Part 2 – Parent

Additional Medical History _____

Bus Concerns –Notified by Transportation

- This student carries Epinephrine auto-injector (**EAI**) and other ordered medications 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 – EAI 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 EAI use and any other ordered medications and this health care plan (plan must be taken).

****Does the student need classroom, school activity, or recess accommodations? ☐ Yes ☐ No. If yes, please contact the school counselor.**

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 by LHP to self-administer his/her own EAI:	☐ Yes	☐ No	Provide extra for office?	☐ Yes ☐ No
My student may carry and use his/her asthma inhaler with LHP approval:	☐ 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 the medication may not be administered by a nurse but may be administered by school staff trained and supervised by an RN.
- I do not give Nutrition Services staff permission to provide the student with a beige lunch tray and allergy identification card to use when eating school breakfast and lunch. ☐ (elementary only)
- I release school staff from any liability in the administration of this medication at school.
- I understand this is a life threatening health care 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.
- 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 the ordered medications.

Parent/Guardian Signature _____ **Date**_____

School Nurse Signature_____ **Date**_____

For School District Nurse Use Only

This Student has demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication.

This student may carry and self-administer their medication: Yes _____ No _____

Device(s) if any, used	**Expiration date(s):**	
Registered Nurse Signature	**Phone #:**	**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.