

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:

MOOUTH--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):

- 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

- Stay with student.**
- CALL 911 – Advise EMS that student has been given Epinephrine**
- Notify parents and school nurse.**
- After Epi auto-injection given, give Benadryl® or antihistamine _____ (ml/mg/cc)**
- 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:
 Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) Albuterol/Levalbuterol unit dose SVN (per nebulizer)
 Levalbuterol 2 puffs (Xopenex®) Other _____
- 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,** _____

- Student may carry & self-administer Epi auto-injector +/- antihistamine Student has demonstrated Epi 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 – (required by USDA Food Guidelines)

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, 354-7270.) **Note: Meals from home provide the safest food option at school.**

LHP Signature: _____

LHP Print 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
- 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