Ref Policy 3420

LIFE-THREATENING ALLERGY CARE PLAN

NAME:		**Severe ALLERGY to:**	Place student picture here
		Other Allergies:	
Please list the specific symptoms the student has experienced in the past:		**Asthma? ☐ Yes (High risk for severe reaction) ☐ No**	
		Routine medications (at home/school):	
School:	**Date of Birth:**	**Grade**	
Bus #	**Car ☐**	**Walk ☐**	**Date of last reaction:**

Location(s) where EpiPen®/Rescue medications is/are stored:

☐ **Office** ☐ **Backpack** ☐ **On Person** ☐ **Coach** ☐ **Other**_____

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911.

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, stomachache/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
OTHER	Some students may experience symptoms other than those listed above

MEDICATION ORDERS

EpiPen®(0.3) ☐ EpiPen, Jr.®(0.15) ☐	Side Effects:
Repeat dose of EpiPen®: ☐ Yes ☐ No	If YES, when:

- It is medically necessary for this student to carry an EpiPen® during school hours. ☐ Yes ☐ No
- Student may self-administer EpiPen®. ☐ Yes ☐ No
- Student has demonstrated use to LHCP. ☐ Yes ☐ No

I request and authorize that the above-named student be administered the above oral medication in accordance with the instructions indicated above from _____(date) to _____(date)(not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Licensed Health Care Provider's Signature:	Date:
Licensed Health Care Provider's Printed Name:	Phone:

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
  - **NOTE TIME_____AM/PM (EpiPen®/adrenaline given)** - **NOTE TIME_____ (Antihistamine given)**
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER EpiPen® is administered.**
- **DO NOT HESITATE to administer EpiPen® and to call 911 even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and EpiPen® is being administered.
- An adult trained in CPR is to stay with student-monitor and begin CPR if necessary.
- Call the School Nurse or Health Services Main Office at _____.
  - Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
- Notify the administrator and parent/guardian.
- Give used EpiPen® to EMS along with a copy of the Care Plan.

Individual Considerations

Bus-Transportation should be alerted to student's allergy.

- This student carries EpiPen® on the bus: ☐ Yes ☐ No
- EpiPen® can be found in: ☐ Backpack ☐ Waist pack ☐ On Person ☐ Other (specify) _____
- Student will sit at front of the bus: ☐ Yes ☐ No

Field Trip Procedures - EpiPen® should accompany student during any off campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: ☐ Yes ☐ No
- Staff members on trip must be trained regarding EpiPen® use and student health care plan (plan must be taken).

CLASSROOM – For Food allergy only

- Student is allowed to eat only the following foods: _____

☐ Those approved by parent.
☐ Middle school or high school student will be making his/her own decision.
☐ Parent/guardian should be advised of any planned parties as early as possible.
☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens.

- Student should have someone accompany him/her in the hallways. ☐ Yes ☐ No

CAFETERIA ☐ NO Restrictions

☐ Student will sit at the classroom table cleansed according to procedure guidelines prior to student's arrival and following the student's departure.

_____

EMERGENCY CONTACTS

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

- I request this medication to be given as ordered by the licensed health care provider.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- 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 licensed health care provider.
- I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No
- This permission to possess and self-administer an EpiPen® may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature Date

Student 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):_____

School Nurse Signature Date

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

The following **staff members** have been given a copy of this Emergency Care Plan: ☐ Parent ☐ Physician ☐ Principal ☐ Teacher ☐ Resource ☐ PE ☐ Music ☐ Library ☐ Science ☐ Transportation ☐ Recess ☐ Office ☐ Other