

ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS

date _____

Allergy to _____

STUDENT NAME		Birthdate			
Grade	School	<input type="checkbox"/> Bus #	<input type="checkbox"/> Walk	<input type="checkbox"/> Drive	
Allergy History <input type="checkbox"/> History of anaphylaxis		Date of Last Reaction		Weight	
Other Allergies:		<input type="checkbox"/> Student has Asthma (increased risk factor for severe reaction)			

Brief Medical History (including current medications)

Epinephrine auto-injector(s) (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: (please check those that are known/history for student)

- MOUTH (Lips, Tongue):** Itching Tingling Swelling **THROAT:** Sense of tightness Hoarseness Hacking cough
- GUT:** Nausea Stomach ache/cramps Vomiting Diarrhea **LUNG:** Shortness of breath Repetitive coughing Wheezing
- SKIN:** Hive Itchy Rash Swelling of the face/extremities **HEART:** Thready pulse Passing out/Fainting Blueness Pale
- GENERAL:** Panic Sudden Fatigue Chills Fear Impending doom

This Section to be Completed by a Licensed Healthcare Provider (LHP)

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

1. Administer Epinephrine auto-injector (EAI) 0.3 mg 0.15 mg (Jr)
 - May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived
2. Call 911 – Advise EMS that Epinephrine has been administered
3. Stay with student
4. After EAI administered, administer _____ (antihistamine) _____ (mg)
5. If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EAI, administer
 - Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) Albuterol/Levalbuterol unit dose SVN (per nebulizer)
 - Levalbuterol 2 puffs (Xopenex®) Other _____

May repeat every _____ minutes as needed for symptoms
6. Notify school nurse and parent/guardian A.Schell, RN 509-660-0400
7. A Student given an EAI must be monitored by medical personnel or a parent and may NOT remain at school
 - Student may carry EAI and/or antihistamine Student has demonstrated EAI use in LHP's office
 - Student may self-administer EAI and/or antihistamine Student has demonstrated inhaler use LHP's office
 - Student may carry and self-administer Inhaler

SIDE EFFECTS of medication(s):

EAI: increased heart rate, Antihistamine: sleepy

Albuterol/Levalbuterol: increased heart rate, shakiness,

******* If student has a food allergy, please complete *Request for Special Dietary Accommodations and Attachment A: Foods to be Omitted and Substituted form* *******

LHP Signature		LHP Print Name	
Start date		End date <input type="checkbox"/> Last day of school <input type="checkbox"/> Other	
Date	Telephone	Fax	

Anaphylaxis Care Plan – Part 2 – Parent/Guardian: STUDENT NAME _____

Food Allergy Accommodations

- Foods and alternative snacks will be approved and provided by parent/guardian
- Notify parent/guardian of any planned parties as early as possible
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens

Student is able to make their own food decisions Yes No

When eating, student requires Specified eating location, where _____
 No restrictions Other _____

Transportation staff should be alerted to student's allergy

- Student carries Epinephrine auto-injector (EAI) on the bus/transportation Yes No
- EAI can be found On person Other (specify) _____
- Student will sit at front of the bus Yes No
- Other (specify) _____

Field Trip/Extracurricular Activity: EAI must accompany student during any off campus activity

- The student must remain with the teacher or parent/guardian during the entire field trip Yes No
- Field trip staff must be trained to medication and health care plan (health care plan must also accompany student)

Other Accommodations _____

- Does student need other classroom, school activity, or recess accommodations Yes No If yes, contact the school counselor or 504 coordinator

EMERGENCY CONTACTS

Parent/ Guardian	Name	Parent/ Guardian	Name		
	Primary #		Primary #		
	Other #		Other #		
	Other #		Other #		
Name:		Relationship:		Phone:	
My child may carry and is trained to self-administer their EAI		<input type="checkbox"/> Yes <input type="checkbox"/> No		Provide extra for office <input type="checkbox"/> Yes <input type="checkbox"/> No	
My child may carry and is trained to self-administer their rescue inhaler		<input type="checkbox"/> Yes <input type="checkbox"/> No		Provide extra for office <input type="checkbox"/> Yes <input type="checkbox"/> No	
My child may carry their EAI (needs assistance to administer)		<input type="checkbox"/> Yes <input type="checkbox"/> No			

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care plan, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- Medical information may be shared with school staff working with my child and EMS, if they are called.
- I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatment in accordance with the licensed healthcare provider's (LHP) instructions.
- This is a life-threatening care plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's severe allergy between the LHP office and the school nurse.

I have reviewed and agree with this health care plan/504 and medication/treatment order.

Parent/Guardian Signature _____ **Date** _____

- I have demonstrated the correct use of the epi pen/antihistamine/inhaler to the medical provider and/or school nurse.
- I agree never to share my medication with another person or use it in an unsafe manner.
- I agree that if I self-administer medication, I will report to an adult at school if the nurse is not available or present.

Student Signature _____

Date _____

For School District Nurse Only

504 Plan

A Registered Nurse has completed a nursing assessment and developed this Anaphylaxis Care Plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication ordered above: Yes No If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: Yes No

Device(s) if any, used _____

Expiration date(s) _____

Registered Nurse Signature _____

Date _____

Phone _____

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.