

# SEVERE ALLERGY REACTION PLAN & MEDICATION ORDERS

**Student has severe allergy to:** \_\_\_\_\_

Nurse's name/phone: \_\_\_\_\_

**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)

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    | 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 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

- Stay with student.
- CALL 911 – Advise EMS that student has been given Epinephrine
- Notify parents and school nurse.
- After EAI 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 EAI 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 _____  |

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

**SIDE EFFECTS of medication(s):**

EAI: increased heart rate, \_\_\_\_\_ Antihistamine: sleepy \_\_\_\_\_

Albuterol/Levalbuterol: increased heart rate, shakiness, \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Student may carry & self-administer EAI +/- or antihistamine | <input type="checkbox"/> Student has demonstrated EAI 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 –**

**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

Check here if student will EAT school provided meals during the entire school year. If so, one of the following must be completed.

- Foods to omit: \_\_\_\_\_  
Suggested general substitutions: \_\_\_\_\_
- Check here if standard substitutions offered in our district are acceptable.  
(Contact district Food Services Manager for details.) **Note: Meals from home provide the safest food option at school.**

LHP Signature: _____		Providers Printed 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

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

- This student carries Epinephrine auto-injector (EAI) 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 this health care plan (plan must be taken).

I wish to meet with the building 504 team to discuss additional accommodations  Yes  No

### EMERGENCY CONTACTS

<b>Mother/Guardian</b>	Name	<b>Father/Guardian</b>	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 EAI:	<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 monitored 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 \_\_\_\_\_

School Nurse Reviewed \_\_\_\_\_ Date \_\_\_\_\_

For School Registered 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	
Registered Nurse Signature _____	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.