_____ALLERGY CARE PLAN AND MEDICATION ORDERS

No History of Anaphylaxis

Plan____ of ____

Place student picture here

STUDENT NAME		**Birthdate**	
Grade	**School**	☐ **Bus #** ☐ **Walk** ☐ **Drive**	
Other Allergies		☐ **Student has Asthma** (increased risk factor for severe reaction)	

Date of last reaction, symptoms experienced

Brief medical history

Antihistamine location	☐ Office	☐ Backpack	☐ On person	☐ Other_____
Inhaler(s) location	☐ Office	☐ Backpack	☐ On person	☐ Other_____

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: _____ (antihistamine) _____(mg)
   ☐ May repeat antihistamine dose after _____minutes
   Antihistamine side effects: ☐ Drowsiness ☐ Hyperactivity ☐ Other: _____
2. If student has asthma and is coughing, wheezing, short of breath, and/or has chest tightness, administer:
   ☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐Other _____
   ☐ **May repeat every _____ minutes as needed for symptoms**
3. Call school nurse and parent/guardian.
4. Student may carry and is trained to self-administer antihistamine. ☐ Yes ☐ No
5. Student may carry and is trained to self-administer rescue inhaler. ☐ Yes ☐ No

SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY
Some Symptoms can be life-threatening—ACT FAST
IF SYMPTOMS INCREASE – DON'T HESITATE TO CALL 911

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 call 911.

USUAL SYMPTOMS of an anaphylactic reaction:

MOUTH—Itching, tingling, or swelling of the lips, tongue, or mouth
GENERAL—Panic, sudden fatigue, chills, fear of impending doom
LUNG—Shortness of breath, repetitive coughing, and/or wheezing
THROAT—Sense of tightness in the throat, hoarseness, hacking cough
SKIN—Hives, itchy rash, and/or swelling about the face or extremities
HEART—"Thready" pulse, "passing out", fainting, blueness, pale
GUT—Nausea, stomach ache/abdominal cramps, vomiting, diarrhea

1. CALL 911 – if symptoms increase
2. Advise EMS that antihistamine has been administered and no epinephrine is available
3. Notify school nurse and parent/guardian of change in condition

* * * * * **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 ☐ Last day of school ☐ Other	
Date	Telephone	Fax:

_____Allergy Care Plan – Part 2 – Parent/Guardian (STUDENT): _____

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: Transportation staff should be alerted to student's allergy

- Student carries allergy medication on the bus ☐ Yes ☐ No
- Medication can be found in ☐ Backpack ☐ On person ☐ Other (specify) _____
- Student will sit at front of the bus ☐ Yes ☐ No
- Other (specify) _____

Field Trip/Extracurricular Activity: *Allergy medication must accompany student during any off-campus activity*

- 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		Parent/Guardian	
	Name		Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #

Name:	Relationship:	Phone:
My child may carry and is trained to self-administer their allergy medication ☐ Yes ☐ No		Provide extra for office ☐
My child may carry and is trained to self-administer their rescue inhaler ☐ Yes ☐ No		Provide extra for office ☐

- 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 care plan includes a medication order, which should be discontinued by the LHP if or when appropriate.
- I authorize the exchange of information about my child's 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 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 allergy 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 has 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

Freeman School District: School Nurse Phone 509-291-4791 ext.102 Fax: 509-291-3636