ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS

Plan ___ **of** ____

Place student picture here

Allergy to _____ ☐ **Allergy Card** **Initials** _____

STUDENT NAME		**Birthdate**	
Grade	**School**	☐ **Bus #** ☐ **Walk** ☐ **Drive**	
Allergy History ☐ **History of anaphylaxis**	**Date of Last Reaction**		**Weight**
Other Allergies:		☐ **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
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 ☐Last day of school ☐ 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		Parent/Guardian	
	Name		Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #

Name:	Relationship:	Phone:

My child may carry and is trained to self-administer their EAI	☐ Yes ☐ No	Provide extra for office	☐ Yes ☐ No
My child may carry and is trained to self-administer their rescue inhaler	☐ Yes ☐ No	Provide extra for office	☐ Yes ☐ No
My child may carry their EAI (needs assistance to administer)	☐ Yes ☐ 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**

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

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.