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. (Identify student specific symptoms)

☐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, fear of impending doom

☐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 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) _____ (ml/mg/cc)
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_____
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

Document time medications were administered and alert EMS when they arrive:

_____	_____	_____	_____
EAI #1	EAI #2	Antihistamine	Inhaler

*** * * * * 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

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**

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.