

## LIFE-THREATENING ALLERGY CARE PLAN

Place  
student  
picture  
here

<b>NAME:</b>		<b>Severe ALLERGY to:</b>	
		<b>Other Allergies:</b>	
<b>Please list the specific symptoms the student has experienced in the past:</b>		Asthma? <input type="checkbox"/> Yes (High risk for severe reaction) <input type="checkbox"/> No	
<b>School:</b>	<b>Date of Birth:</b>	<b>Grade:</b>	<b>Routine medications (at home/school):</b>
<b>Bus #</b>	Car <input type="checkbox"/>	Walk <input type="checkbox"/>	<b>Date of last reaction:</b>
<b>Location(s) where EpiPen®/Rescue medications is/are stored:</b>			
<input type="checkbox"/> Office <input type="checkbox"/> Backpack <input type="checkbox"/> On Person <input type="checkbox"/> Coach <input type="checkbox"/> Other _____			

**Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911**

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, stomachache/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
OTHER	Some students may experience symptoms other than those listed above

### MEDICATION ORDERS

EpiPen® (0.3) <input type="checkbox"/>	EpiPen Jr.® (0.15) <input type="checkbox"/>	Side Effects:
Repeat dose of EpiPen®: <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, when
Antihistamine: _____ cc/mg		Give: _____ Teaspoons _____ Tablets by mouth
Side Effects:		
♦ It is medically necessary for this student to carry an EpiPen® during school hours. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ Student may self-administer EpiPen®. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ Student has demonstrated use to LHCP. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Licensed Health Care Provider's Signature:		Date:
Licensed Health Care Provider's Printed Name:		Phone:                      Fax Number:

### ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
- ♦ **NOTE TIME** \_\_\_\_\_ AM/PM (EpiPen®/adrenaline given) ♦ **NOTE TIME** \_\_\_\_\_ AM/PM (Antihistamine given)
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER EpiPen® is administered.**
- **DO NOT HESITATE to administer EpiPen® and to call 911 even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and EpiPen® is being administered.
- An adult trained in CPR is to stay with student—monitor and begin CPR if necessary.
- Call the School Nurse or Health Services Main Office at \_\_\_\_\_.
- ♦ Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
- ♦ Notify the administrator and parent/guardian.
- ♦ Dispose of used EpiPen® in “sharps” container or give to EMS along with a copy of the Care Plan.

**Individual Considerations**

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

- ◆ This student carries EpiPen® on the bus:  Yes  No
- ◆ EpiPen® can be found in:  Backpack  Waistpack  On Person  Other (specify) \_\_\_\_\_
- ◆ Student will sit at front of the bus:  Yes  No
- ◆ Other (specify): \_\_\_\_\_

**Field Trip Procedures – EpiPen® should accompany student during any off campus activities.**

- ◆ Student should remain with the teacher or parent/guardian during the entire field trip:  Yes  No
- ◆ Staff members on trip must be trained regarding EpiPen® use and student health care plan (plan must be taken).
- ◆ Other (specify) \_\_\_\_\_

**CLASSROOM –For Food allergy only**

- ◆ Student is allowed to eat only the following foods: \_\_\_\_\_
- Those in manufacturer’s packaging with ingredients listed and determined allergen-safe by the nurse/parent or \_\_\_\_\_
- Those approved by parent.
- Middle school or high school student will be making his/her own decision.
- Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- Parent/guardian should be advised of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ◆ Student should have someone accompany him/her in the hallways.  Yes  No
- ◆ Other (specify): \_\_\_\_\_

**CAFETERIA**  NO Restrictions

- Student will sit at a specified allergy table.
- Student will sit at the classroom table cleansed according to procedure guidelines prior to student’s arrival and following student’s departure.
- Student will sit at the classroom table at a specified location.
- ◆ Cafeteria manager and hostess should be alerted to the student’s allergy.
- ◆ Other: \_\_\_\_\_

**EMERGENCY CONTACTS**

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:
4.	Relationship:	Phone:

- ◆ I request this medication to be given as ordered by the licensed health care provider.
- ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- ◆ 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 licensed health care provider.
- ◆ I request and authorize my child to carry and/or self-administer their medication. \_\_\_\_\_ Yes \_\_\_\_\_ No
- ◆ This permission to possess and self-administer an EpiPen® may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature

Date

Student demonstrated to the nurse the skill necessary to use the medication and any device necessary to self-administer the medication.

Device(s) if any, used: \_\_\_\_\_ Expiration date(s): \_\_\_\_\_

School 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.