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| SEVERE ALLERGY REACTION/504 PLAN & MEDICATION ORDERS | | | | | | | | | | | |
| **Student has severe allergy to:** Click or tap here to enter text. | | | | | | | | | | | |
| Students Name: Click or tap here to enter text. | | | | | | | Birthdate:Click or tap to enter a date. | | Weight:Click or tap here to enter text. | | |
| Grade:Click or tap here to enter text. | School:Click or tap here to enter text. | | | Bus #Click or tap here to enter text. | | | | | | Walk | Drive |
| Allergy History: History of anaphylaxis/severe reaction Skin testing indicates allergy | | | | | | | | | | | |
| Date of Last reaction:Click or tap to enter a date. | | | | | | | Other Allergies: Click or tap here to enter text. | | | | |
| Student has Asthma (increased risk factor for severe reaction) | | | | | | | | | | | |
| Epinephrine auto-injector (EAI) Location: | Office | | Backpack | | | On person | | Other: Click or tap here to enter text. | | | |
| Inhaler(s) Location: | Office | | Backpack | | | On person | | Other: Click or tap here to enter text. | | | |
| 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: (Students usual s/s are in bold, italics, and/or underlined)** | | | | | | | | | | | |
| MOUTH- Itching, tingling, or swelling of the lips, tongue, or moth | | | | | | | SKIN-Hives, itchy, and/or selling 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 | | | | | | | | | | | |
| This Section to Be Completed by A Licensed Healthcare Provider (LHP): | | | | | | | | | | | |
| 1. 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. | | | | | | | | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | | | Click or tap here to enter text. | | Click or tap here to enter text. | | |
| EAI #1 | | EAI #2 | | | | | Antihistamine | | Inhaler | | |
|  | | | | | | | | | | | |
| 1. Say with student. | | | | | | | | | | | |
| 1. Call 911 – Advise EMS that student has been given Epinephrine | | | | | | | | | | | |
| 1. Notify parents and school nurse. | | | | | | | | | | | |
| 1. After EAI given, give Benadryl or antihistamine Click or tap here to enter text.ml/mg/cc) | | | | | | | | | | | |
| 1. If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction; After EAI, administer: | | | | | | | | | | | |
| Albuterol 2 puffs (Pro-air, Ventolin HFA, Proventil) | | | | | | | Albuterol/Levalbuterol unit dose SVN (per nebulizer) | | | | |
| Levalbuterol 2 puffs (Xopenex) | | | | | | | Other Click or tap here to enter text. | | | | |
| 1. 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, | | | | | | |  | | | | |
| Student may carry & self-administer EAI +/or antihistamine | | | | | | | Student has demonstrated EAI use in LHP’s Office | | | | |
| Student may carry & self-administer Inhaler | | | | | | | Student has demonstrated inhaler use LHP’s office | | | | |
|  | | | | | | | | | | | |
| PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY- (required by USDA Food Guidelines) | | | | | | | | | | | |
| Check here if student will EAT school provided meals during the entire school year. If so, one of the following must be completed. | | | | | | | | | | | |
| 1. Foods to omit:Click or tap here to enter text. | | | | | | | | | | | |
| Suggested general substitutions:Click or tap here to enter text. | | | | | | | | | | | |
| 1. Check here is 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: | | | | | LHP Print Name:Click or tap here to enter text. | | | | | | |
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| Start date:Click or tap to enter a date. |  | | End date:Click or tap to enter a date.  Last day of school  Other:Click or tap here to enter text. | |
| Date: Click or tap to enter a date. | |  | | Telephone #:Click or tap here to enter text. Fax #:Click or tap here to enter text. |

# Care Plan for Severe Allergy-Part 2- Parent

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| **Student Name:** | Click or tap here to enter text. | | | | | | | | |
|  | | | | | | | | | |
| **Brief Medical History:** | | Click or tap here to enter text. | | | | | | | |
|  | | | | | | | | | |
| **Food Allergy Accommodations:** | | | Click or tap here to enter text. | | | | | | |
|  | | | | | | | | |  |
| * Foods and alternative snacks will be approved or provided by parent/guardian. | | | | | | | | | Yes  No |
| * Parent /guardian should be reviewed by the teaching staff to avoid specified allergens. | | | | | | | | | |
| * 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 Click or tap here to enter text. | | | |
| 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)Click or tap here to enter text. | | | | | | | | | |
| * Student will sit at front of the bus? Yes No | | | | | | | | | |
| **Field Trip Procedures-EAI must accompany student during any off-campus activities.** | | | | | | | | | |
| * This 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** | | | | | | | | | |
| **MOTHER/GUARDIAN:** | | | | | | | | | |
| Name:Click or tap here to enter text. | | | | | Phone:Click or tap here to enter text. | | | | |
| Work Phone:Click or tap here to enter text. | | | | | OtherClick or tap here to enter text. | | | | |
| **FATHER/GUARDIAN:** | | | | | | | | | |
| Name:Click or tap here to enter text. | | | | | Phone:Click or tap here to enter text. | | | | |
| Work Phone:Click or tap here to enter text. | | | | | OtherClick or tap here to enter text. | | | | |
| **ADDITIONAL EMERGENCY CONTACTS** | | | | |  | | | | |
| 1. | | | | Relationship: | | | | Phone: | |
| 2. | | | | Relationship: | | | | Phone: | |
| My child may carry and is trained to self-administer their own EAI: YES NO Provide extra for office? YES NO | | | | | | | | | |
| My child may carry and use their asthma inhaler YES NO Provide extra for office?YES 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 administration of this medication at school.
* I understand this is a life-threatening plan an 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.
* I understand that my child 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.

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|  |  | Click or tap to enter a date. |
| Parent/Guardian Signature |  | Date |

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| **For School Registered Nurse’s Use Only**  This student has demonstrated to the nurse, the skill to use the medication and any device necessary to administer the medication ordered whither self-administered or not. This plan has been reviewed by a register nurse | | | | |
|  | | | | |
|  |  | Click or tap here to enter text. |  | Click or tap to enter a date. |
| Registered Nurse Signature |  | Phone |  | Date |

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members involved wit the student Rev 8/2021