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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
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| 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 |
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| 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**.
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| 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. |
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| **Brief Medical History:** | Click or tap here to enter text. |
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| **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