

SEVERE ALLERGIC REACTION/504 PLAN & MEDICATION ORDERS

Insert student picture here

Student has severe allergy to: _____

School Nurse phone: _____

Date Plan Developed/Revised/Reviewed: _____

NAME: _____			Birthdate: _____		
Grade: _____	School: _____	<input type="checkbox"/> Bus	<input type="checkbox"/> Walk	<input type="checkbox"/> Drive	
Allergy History: <input type="checkbox"/> History of anaphylaxis/severe reaction <input type="checkbox"/> Skin testing indicates allergy			Date of Last Reaction: _____		
Other Allergies: _____			<input type="checkbox"/> Student has Asthma (increased risk factor for severe reaction)		
Epi auto-injector(s) location: <input type="checkbox"/> OFFICE <input type="checkbox"/> BACKPACK <input type="checkbox"/> ON PERSON <input type="checkbox"/> OTHER: _____					
Inhaler(s) location: <input type="checkbox"/> OFFICE <input type="checkbox"/> BACKPACK <input type="checkbox"/> ON PERSON <input type="checkbox"/> N/A <input type="checkbox"/> 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 Epi auto-injector and call 911.					
USUAL SYMPTOMS of an allergic reaction: 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, chills, fear of impending doom					

This Section to Be Completed By A Licensed Healthcare Provider (LHP):

If a student has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to something allergic to):

- Give Epi auto-injector** 0.3 mg Jr. 0.15 mg
 May repeat Epi auto-injector (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.

Epi-pen #1	Epi-pen #2	Antihistamine	Inhaler

- Stay with student.**
- CALL 911 – Advise EMS that student has been given Epinephrine**
- Notify parents and school nurse.**
- After Epi auto-injection given, give Benadryl® or antihistamine _____ (ml/mg/cc)**
- If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction,**
 After Epi auto-injection and antihistamine, may give:
 Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) Albuterol/ Levalbuterol unit dose SVN (per nebulizer)
 Levalbuterol 2 puffs (Xopenex®) Other _____
- A Student given an Epi auto-injector must be monitored by medical personnel or a parent & may NOT remain at school.**

SIDE EFFECTS of medication(s):

Epi auto-injector: **increased heart rate,** _____ Antihistamine: **sleepy,** _____

Albuterol/Levalbuterol: **increased heart rate, shakiness,** _____

- | | |
|---|---|
| <input type="checkbox"/> Student may carry Epi auto-injector +/- or antihistamine | <input type="checkbox"/> Student has demonstrated Epi auto-injector use in LHP's office |
| <input type="checkbox"/> Student may self-administer Epi auto-injector +/- or antihistamine | |
| <input type="checkbox"/> Student may carry & self-administer Inhaler (if applicable) | <input type="checkbox"/> 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.

- Foods to omit:** _____
- Check here if food substitutions are acceptable. (Contact district Food Services Manager for details and required form.)**

Note: Meals from home provide the safest food option at school.

LHP Signature: _____		Print Name: _____	
Start date: _____	End date (not to exceed current school year): _____	<input type="checkbox"/> Last day of school	<input type="checkbox"/> Other: _____
Date: _____	Telephone #: _____	Fax #: _____	

Student: _____

Care Plan for Severe Allergy – Part 2 – Parent

Brief Medical History _____

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
- Parent/guardian should be notified of any planned parties as early as possible.
- 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? _____
 No restrictions Other (specify) _____

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

- This student carries Epi auto-injector on the bus? Yes No Where? _____
- Epi auto-injector can be found in Backpack Waist pack On Person Other (specify) _____
- Student will sit at front of the bus? Yes No
- Other concerns (specify) _____

Field Trip Procedures – Epi auto-injector must accompany student during any off campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip.
- Staff members on trip are trained regarding Epi auto-injector use and this health care plan.

EMERGENCY CONTACTS

Mother/Guardian	Name	Father/Guardian	Name
	Home Phone		Home Phone
	Work Phone		Work Phone
	Other		Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

My student may carry his/her own Epi auto-injector: <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide extra epi-pen for office? <input type="checkbox"/> Yes <input type="checkbox"/> No
My student is trained to self-administer his/her own Epi auto-injector: <input type="checkbox"/> Yes <input type="checkbox"/> No	
My student may carry and use his/her asthma inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Provide extra inhaler for office? <input type="checkbox"/> Yes <input type="checkbox"/> No

- I give consent for the implementation of this Section 504 Plan.
- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e.: doctor, nurse practitioner, PAC).
- I authorize the exchange of medical information about my child's allergy between the LHP office and school nurse.
- I understand that any medication will be given by either self-administration (if prescribed), or a school nurse or a trained school staff member.
I release school staff from any liability in the administration of this medication at school.
- 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 professional.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
 - ▶ The 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.

Parent/Guardian Signature

Date

◇ **Written Notice for Health Care/Section 504 Plan:** The purpose of this written notice is to inform you that the District is proposing to **Initiate** OR **Change/Update** your child’s Health Care/Section 504 Plan as described above. A copy of *Your Rights Under Section 504* is attached or can be found at <http://bisd303.org/Page/499>.

For District Nurse’s Use Only

Student has 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