Community Education & Recreation Department

A Division of Mankato Area Public Schools

INDIVIDUAL ALLERGY HEALTH PLAN / EMERGENCY CARE PLAN

Child's Name: ____ Birth Date: ____________

Program Name/Site: ____ Grade: ______________

* *

1. My child is allergic to:____
2. Reaction occurs from: ☐ ingestion ☐contact ☐inhalation ☐insect sting
3. My child has had a life threatening, anaphylactic reaction to this allergen: ☐ YES ☐ NO
4. Does your child also have asthma? ☐ YES (*Higher risk for severe allergic reaction*) ☐ NO

SIGNS OF AN ALLERGIC REACTION INCLUDE:

(Please check symptoms most common to your child.)

__MOUTH	__SKIN	__GUT	__THROAT	__LUNGS	__HEART	__OTHER
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	feeling something bad is about to happen, anxiety, confusion

5. History of reaction (date of last reaction / signs & symptoms of reaction): ______________________

____

6. Avoidance strategies used at home: ____
7. Does your child recognize these signs and symptoms? ☐ YES ☐ NO
8. Will your child require a rescue medication to be given during program hours? ☐ YES ☐ NO
9. Health Care Provider Name: ______________________________ Phone #: ________________
10. Emergency Contacts (*list in order of who to call first*)

Name: ____________________ Relationship:__________ Phone:___________Phone:__________

Name: ____________________ Relationship:__________ Phone:___________Phone:__________

OVER

Child's Name:_____

CER ALLERGY ACTION / EMERGENCY PLAN:

If child has an epinephrine auto-injector for a bee sting allergy, it will be immediately given if stung*

1. Give prescribed medications if available. If symptoms do not improve, or symptoms return, additional dose of epinephrine can be given (if ordered by a licensed prescriber and authorized by parent/guardian).
2. Call 911. Tell emergency dispatcher the person may be having anaphylaxis.
3. Lay the person flat, raise legs, and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. Calm and reassure student.
4. Contact parents/guardian.
5. Emergency transportation to hospital is recommended for further monitoring.

(The Consent Form for Administration of Emergency Allergy Medication for an epinephrine auto-injector must be completed and signed by the health care provider and parent.)

CER MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

☐ **No epinephrine auto-injector at program.** Follow the above CER Allergy Action/Emergency Plan.

☐ **Epinephrine auto-injector to be administered as ordered**. The epinephrine auto-injector must be properly labeled for the student.

1. I understand that this plan may be shared with all program staff working directly with my child.
2. I will contact the program if a change in the current plan is needed.
3. I will provide this medication in the original, properly labeled pharmacy container to program site (see criteria for proper labeling on Consent For for Administration of Emergency Allergy Medication, which must be provided with this form if epinephrine is to be given).

Parent/Guardian Signature _____ **Date** _____

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CONSENT FORM FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION

****Before medication can be administered by CER program personnel this form must be completed and on file****

Child's Name: ____ Birth Date: _______________

Program Site: ____ Grade: __________________

* *

PHYSICIAN / LICENSED PRESCRIBER ORDER

Epinephrine auto-injector type: ___________________________ Dose: ☐ 0.15 mg IM **or** ☐ 0.3 mg IM

Instructions for giving medication:____

Criteria for repeat dosing:____

Possible side effects: ____

Other/Additional Directions: ____

Emergency Allergy Medication should be administered for the following type(s) of symptoms:

__MOUTH	__SKIN	__GUT	__THROAT	__LUNGS	__HEART	__OTHER
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	feeling something bad is about to happen, anxiety, confusion

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE:_________________________________ Date: _______

Print Name:_______________________________________ Clinic: ______________________________

Phone #:____________________________ Fax #: __________________________

OVER

Child's Name: _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during CER program hours by CER program staff as ordered by the physician/licensed prescriber.
2. I will provide this medication in the original, properly labeled pharmacy container.
3. I authorize the CER Program Coordinator/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the CER Program Coordinator/designee to communicate with appropriate CER program personnel regarding this medication and emergency care plan for my child.
5. I release CER program personnel from any liability in relation to the administration of this medication during the program.
6. I have read and understand the Medication Guidelines included with this form (below).

Parent/Guardian Signature:_____ Date:_____

* *

GUIDELINES FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Allergy Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian.
    a. Altered forms of medication will not be accepted or administered during a CER program.
    b. Narcotics/medical cannabis will not be administered at CER program.
    c. Aspirin-containing products will not be administered at CER program.
    d. Only FDA approved treatments will be provided at CER program.
2. A new medication consent form is required year and when the medication dosage or instructions for administering the medication are changed.
3. If the medication is discontinued, a physician/licensed prescriber is requested.
4. The medication must be brought to and from CER program by a parent/guardian in its original container.
5. The following information must be on the medication container:
    a. Child's full name
    b. Name and dosage of medication
    c. Directions for administration must match the authorization form
    d. Physician/Licensed Prescriber name
    e. Date (must be current)
6. Medications are not to be carried by the child and will be kept in a locked box/cabinet designated for medication.