South Kitsap School District

1962 Hoover Ave. SE, Port Orchard, WA 98366 360-874-7000

SEVERE ALLERGIC REACTION PLAN & MEDICATION ORDERS

Place student picture here

Student has severe allergy to:

Nurse phone:

Date Plan Developed/Revised/Reviewed:

NAME:			**Birthdate:**	
Grade:	**School:**	☐ **Bus**	☐ **Walk**	☐ **Drive**
Allergy History: ☐ History of anaphylaxis/severe reaction ☐ Skin testing indicates allergy **Date of Last Reaction**:				
Other Allergies:			☐ **Student has Asthma** (increased risk factor for severe reaction)	
Epi auto-injector(s) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER:				
Inhaler(s) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ 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

THROAT--Sense of tightness in the throat, hoarseness and hacking cough

LUNG--Shortness of breath, repetitive coughing, and/or wheezing

GENERAL--Panic, sudden fatigue, chills, fear of impending doom

SKIN--Hives, itchy rash, and/or swelling about the face or extremities

GUT--Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea

HEART --"Thready" pulse, "passing out", fainting, blueness, pale

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):

1. **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

2. **Stay with student.**
3. **CALL 911 – Advise EMS that student has been given Epinephrine**
4. **Notify parents and school nurse.**
5. **After Epi auto-injection given, give Benadryl® or antihistamine_____(ml/mg/cc)**
6. **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_____

7. **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,_____**

☐ Student may carry & self administer Epi auto-injector +/or antihistamine ☐ Student has demonstrated Epi auto-injector 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:_____** **Note: Meals from home provide the safest food option at school.**

Suggested general substitutions:_____

2. ☐ **Check here if standard substitutions offered in our district are acceptable. (Contact district Food Services Manager for details.)**

LHP Signature:	Print Name:	
Start date:	End date (not to exceed current school year):	☐ Last day of school ☐ 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____

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 (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? ☐ Yes ☐ No
- Staff members on trip must be trained regarding Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify): ____

EMERGENCY CONTACTS

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

ADDITIONAL EMERGENCY CONTACTS

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

My student may carry and is trained to self-administer his/her own Epi auto-injector: ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No
My student may carry and use his/her 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 his medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff. 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.
  - 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.

Parent/Guardian Signature **Date**

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**

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. Rev 9/10/10