RSU No. 5 Durham-Freeport-Pownal

ALLERGY/ANAPHYLAXIS CARE PLAN

Student Name _____ Birthdate _____ School: _____
School Nurse_____ Phone _____Fax _____
Healthcare Provider _____ Preferred Hospital _____
HISTORY OF ASTHMA: ☐ No ☐ Yes-Higher risk for severe reaction

ADD PHOTO HERE

ALLERGY: (check appropriate) To be completed by Healthcare Provider

- ☐ Foods (list): _____
- ☐ Medications (list): _____
- ☐ Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)
- ☐ Stinging Insects (list): _____

RECOGNITION & TREATMENT:

Chart to be completed by Healthcare Provider ONLY		Give CHECKED Medication	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	☐ Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut +	Nausea, abdominal cramps, vomiting, diarrhea		
Throat +	Tightening of throat, hoarseness, hacking cough		
Lung +	Shortness of breath, repetitive coughing, wheezing		
Heart +	Thready pulse, low BP, fainting, pale, blueness		
Neuro +	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. + = Potentially life-threatening.			

DOSAGE:

Epinephrine: Inject into outer thigh (through clothing) ☐ 0.3 mg OR ☐ 0.15 mg
Antihistamine: Diphenhydramine (Benadryl®) _____mg.

☐ This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one) and antihistamine medication. It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently as well as antihistamine medication.

☐ It is my professional opinion (PCP) that this student **SHOULD NOT** carry an auto-injector.

Healthcare Provider Signature _____Phone: _____ Date _____

EMERGENCY PROTOCOL:

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR, accompany to ER if no parent/guardian are available.

Adapted from Allergy & Asthma Foundation of America 5/2018 Nsg PLC

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ALLERGY/ANAPHYLAXIS CARE PLAN

To be completed by the Parent/ Guardian

Emergency Contacts:

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

Parent/Guardian AUTHORIZATIONS:

- ☐ I want this allergy plan implemented for my child and **I do** want my child to self-carry/self-administer antihistamine and epinephrine.
- ☐ I want this plan implemented for my child and **I do not** want my child to self-carry/ self-administer antihistamine and epinephrine.

Permission to administer Medication: I request and give permission for the school nurse or other unlicensed trained school personnel to administer the above medication to my child. Information regarding this medication may be shared with the appropriate school personnel. **NOTE:** Any changes to the information above shall require a new Request/Permission form.

Permission to Contact Prescribing Physician : I understand and agree that if the school nurse has questions regarding the physician's order, I give my permission for the school nurse to contact my child's physician and obtain additional information about the medication, administration schedule, and the effects of the medication on my child's learning. I consent to the physician providing that information.

Medication Removal: I understand that I must pick up any medication no longer required or remaining at the end of the school year or it will be appropriately discarded.

After School Activities: I understand I am responsible for auto injectors for before and after school activities.

Parent/Guardian Signature: _____ Date: _____

Student Agreement:

- ☐ I have been trained in the use of my auto-injector and allergy medication (antihistamine) and understand the signs and symptoms for which they are given;
- ☐ I agree to carry my auto-injector and allergy medicine with e at all time;
- ☐ I will notify a responsible adult **Immediately** when my auto-injector (epinephrine) or allergy medicine (antihistamine) is used.
- ☐ I will not share my medication with other students or leave my auto-injector or allergy medicine unattended;
- ☐ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Date: _____

Approved by Nurse: Signature: _____ Date: _____

Medication Given	Date	Time	Signature

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