McPherson County Schools Health Services

Smoky Valley USD 400 McPherson USD 418 Canton/Galva USD 419 Moundridge USD 423 Inman USD 448

Severe Allergy Care Plan

Student Name:		DOB:
Parents:		Phone:
Address:		
Physician:		Physician Phone:
School Nurse:		Phone:
Grade:	Teacher:	Medication Allergies:

History

My student is allergic to:
His/her past allergic reactions were at age:
If applicable, the food ingested was:
If not ingested, the contact was:
How soon after the exposure do these symptoms occur?

Allergic to:	Reaction:	Treatment:
Allergic to:	Reaction:	Treatment:

Instructions for field trips:

Students Emergency Medications will be kept:

Current Medications:

Medication:	Side Effects:
Medication:	Side Effects:

For FOOD Allergies

*Classroom snacks/birthday treats from other students – It is highly recommended that parents provide a supply of individualized snacks for early childhood and younger elementary-age students with known food allergies. Please indicate your preference by checking one of the following:

_____ I will provide all of my child's food. He/she is not to eat other snacks/treats at school unless I am present or have provided prior approval specific to item.

_____My child is knowledgeable about foods to avoid and may eat snack/treats brought by other students.

*Lunchroom Seating – An option for young students with severe peanut/nut allergy is to sit at a designated "hot lunch/allergy" only table. Please indicate your preference by checking one of the following:

_____My child should sit at a "hot lunch/allergy" only table

_____My child does NOT need to sit at a "hot lunch/allergy" table

I, _____(Parent/Guardian) understand and agree to contents of this health care plan. I also agree this plan will be effective from this time until the end of the school year. I also understand either party, at any time, may request to re-evaluate this plan.

Parent/guardian signature: _____ Date:_____ Rev. 2/2015

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name:	DOB:
Allergy to:	Weight:

MEDICATIONS/DOSES

Epinephrine Brand:_____Dose ☐ 0.15mg IM ☐ 0.3mg IM

Antihistamine Brand or Generic:_____ Dose:_____

Other (inhaler-bronchodilator)_____Dose:_____

Extremely reactive to the following foods:_____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Does this student have asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

If This Happens	Do This	Auto-Injector Directions
Mild Symptoms: • NOSE: Itchy/runny nose, sneezing • MOUTH: Itchy mouth • SKIN: A few hives, mild itch • GUT: Mild nausea/discomfort	*If student is having **only one mild symptom** antihistamines may be given, if ordered by a healthcare provider. *If student is having mild symptoms from **more than one symptom area** give epinephrine	**Directions for Auvi-Q** **1)**Remove the outer case of Auvi-Q. This will automatically activate the voice instructions. **2)**Pull off red safety guard. **3)**Place black end against mid-outer thigh, press firmly and hold for 5 seconds
Severe Symptoms: • LUNG: Shortness of breath, wheezing, repetitive cough • HEART: Pale, blue, faint, weak pulse, dizzy • THROAT: Tight, hoarse, trouble breathing/swallowing, significant swelling of tongue and/or lips • SKIN: Many hives over body, widespread redness • GUT: Repetitive vomiting, severe diarrhea • OTHER: Feeling something bad is about to happen, anxiety, confusion	*INJECT EPINEPHRINE IMMEDIATELY * Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive. *Consider giving additional medications following epinephrine (antihistamine or inhaler) *If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose. *Alert emergency contacts *Transport to ER even if symptoms resolve.	**Directions for EpiPen:** **1)** Pull off blue safety cap **2)** Place orange tip on upper outer thigh at right angle to leg, through clothes. If thigh cannot be used, use the deltoid muscle on upper arm. **3)** Press Epipen hard into thigh until auto-injector mechanism functions. Hold in place 10 seconds, then remove. Give EpiPen to EMS personnel or discard in sharps container

Licensed Health Care Provider Signature _____Date _____
(M.D., D.O., D.D.S., A.R.N.P., or P.A.)

PARENT / GUARDIAN PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE

I hereby give my permission for my child to take the above prescribed medication at school as ordered. I understand that it is my responsibility to furnish the medication in the original container appropriately labeled by the pharmacy / manufacturer or physician stating the name of the medication, the dosage, time to be given, and number of days to be administered at school. Any school employee who administers any medication in accordance with written instructions from the prescribing health care provider shall not be liable for damages as a result of any adverse drug reaction suffered by the student. If the student self-administers the medication, I acknowledge that the above named student has been instructed on self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication. I understand the school policy regarding medication.

I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises. I may revoke this consent to release information in writing and dated at any time except to the extent that action has been taken or information disclosed pursuant to signed consent. This consent shall remain in effect for a period of one year from signature date. To revoke this authorization, I should contact: my child's school or McPherson County Special Education Cooperative, 514 N Main, McPherson, KS 67460. Once information is disclosed, it may no longer be subject to HIPAA protections.

EMERGENCY MEDICATION ONLY: My child may carry inhaler / emergency medication (asthma, severe allergic reaction, diabetes management) with him/her. He / She has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed.

Parent/Guardian Signature_____Date_____

Printed Name of Parent/Guardian_____