

ISD #477 School Health Services

ALLERGY ACTION PLAN



PRINCETON
DISTRICT CENTER

Physician: Please complete this page **Parent/Guardian: Please complete page 2**

Student _____ Date of Birth _____ Grade _____
 School _____ Teacher _____ Bus: Yes or No

Physician: _____
 Parent/Guardian _____ H# _____ W# _____ C# _____
 Parent/Guardian _____ H# _____ W# _____ C# _____

ALLERGY TO: ☐ Peanuts ☐ Nuts (Specify) _____ ☐ Eggs ☐ Seafood (Specify) _____
☐ Latex ☐ Insect Bites (Specify) _____ ☐ Other (Specify) _____

History of Asthma: ☐ Yes* ☐ No History of Anaphylaxis: ☐ Yes* ☐ No *More at risk for severe reaction
 Date of last reaction: _____ Explain what happened: _____

MEDICATIONS

EPINEPHRINE: *keep 2 doses on hand*

☐ EpiPen® Dose _____
☐ Adrenaclick™ Dose _____
☐ Auvi-Q™ Dose _____

ANTI HISTAMINE:

☐ Benadryl (also known as Diphenhydramine)
 Dose _____
☐ Other antihistamine _____

Epinephrine located: ☐ Health Services ☐ Self carry ☐ Backpack ☐ Other _____

Student has been instructed how to use their epinephrine: ☐ Yes ☐ No

If able, student will give themselves epinephrine: ☐ Yes ☐ No

☐ 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.

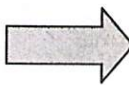
Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
 HEART: Pale, blue, faint, weak pulse, dizzy, confused
 THROAT: Tight, hoarse, trouble breathing/swallowing
 MOUTH: Obstructive swelling (tongue and/or lips)
 SKIN: Many hives over body

Or combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
 GUT: Vomiting, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications.*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE.**

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
 SKIN: A few hives around mouth/face, mild itch
 GUT: Mild nausea/discomfort



1. **GIVE ANTIHISTAMINE**
2. Call parent and LSN
3. If symptoms progress (see above), **USE EPINEPHRINE**

Monitoring

Stay with student; call parent and LSN. Tell 911 that epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised.

Physician Authorization

I authorize the above plan to be followed in school.

Physician's Signature: _____ Printed Name of Physician: _____ Date: _____

Parent/Guardian: Please complete this page

Student _____ Date of Birth _____ School _____ Grade _____

FIELD TRIPS: • Send prescribed medications and Action Plan.
• 911 will be called, as needed.

BUS INFORMATION: Bus cards are no longer being mailed out. ISD 477 will inform the bus company that your child has a medical action plan on file with the Health Office. Please notify the bus company directly of any specific directions for your child's care while riding the bus.

SELF-CARRY EPINEPHRINE CONTRACT

Based on student's knowledge and skills to safely possess based on LSN discretion

I give permission for my child, _____ to carry their epinephrine. My child understands that they must never share their epinephrine with others and that they must go to Health Services immediately after use of epinephrine. I will notify the school of changes in medication or my child's condition. **Please note: It is recommended to have a back-up epinephrine that is kept in Health Services.**

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s) i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.

NOTE: Medication must be supplied in original/prescription bottle.

Parent/Guardian Signature: _____ Relationship to Student: _____ Date: _____

PARENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION FOR ACTION PLAN

I understand that this action plan may be revoked at anytime in writing, and expires in one calendar year.
I authorize the above plan to be followed in school.

Parent/Guardian Signature: _____ Date: _____



Emergency Care Plan TAKE ON ALL FIELD TRIPS

☐ Attach a copy of Student Emergency Card

ANAPHYLAXIS INFORMATION SHEET (life threatening allergic reaction)

Triggered by various sources such as: nuts or peanuts, shellfish seafood, bee stings, latex, and others.

Medically diagnosed *life threatening emergency.

PREVENTION STRATEGIES:

- Student may or may not know what to avoid.
- Student may or may not tell other people about his/her allergies.
- Student may or may not tell an adult immediately if exposed to an allergen (i.e. stung by a bee, ate a peanut, etc.)
- Student may or may not wear a medical alert bracelet or necklace.
- Student may or may not avoid wearing brightly colored clothing or perfumed products which may attract insects.
- Student may or may not avoid contact with animals in classroom.
- Student may or may not ask about ingredients in foods, if unsure about contents.
- Student may or may not firmly refuse food that might be a problem food.

SIGNS OF EMERGENCY:

Signs of an allergic reaction * = Life threatening

Systems: Symptoms:

- | | |
|-----------|--|
| • MOUTH | itching and swelling of the lips, tongue, or mouth |
| • THROAT* | itching and/or a sense of tightness in the throat, hoarseness, and cough |
| • SKIN | hives, itchy rash, and/or swelling about the face or extremities |
| • GUT | nausea, abdominal cramps, vomiting, and/or diarrhea |
| • LUNG* | shortness of breath, repetitive coughing, and/or wheezing |
| • HEART* | "thready" pulse, "passing-out" |

If you see this

ACTION FOR GENERAL SCHOOL STAFF/TEACHERS:

1. Notify building Health Services staff in Health Office. (Be familiar with phone extension number)
 2. Health Services staff to come to classroom with medication.
- or -
3. Health Services staff will ask that student be accompanied by an adult to Health Office.
 4. Health Services staff is responsible to provide care to student unless delegated to teaching staff by a school nurse (i.e. Field Trips).

Do this

FIELD TRIP ACTIONS:

1. Information sheet and all student medication related to a potential anaphylaxis should be brought on the field trip.
2. There must be at least one teacher that has been taught and delegated proper emergency medication administration. Delegation process MUST be taught by a Licensed School Nurse.
3. If a student is in need of emergency Epinephrine, trained teacher should administer according to directions below:

or Field Trips - Do this

DIRECTIONS FOR USE

1. Pull out gray safety cap.
2. Place black tip on outer thigh.
3. Using a quick motion, press hard until injector functions. Hold in place for several seconds.

4. An adult should call 911. Notify school Health Office when 911 is called. Inform paramedics of exposure prior to symptom.

STUDENT OUTCOMES: (✓ all that apply)

1. Student will participate in school activities with modifications as needed.
2. Student will demonstrate/describe allergens and signs of an emergency.
3. Other: _____

(OVER)

TRAINED STAFF MEMBERS

1. _____
2. _____
3. _____

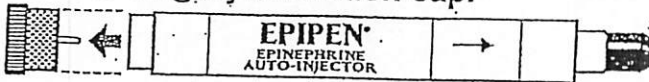
Room _____

Room _____

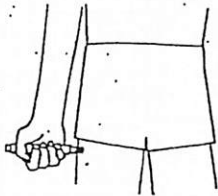
Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions



- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.

