School Year ________

Andover Regional School District TWO-STEP ALLERGY/ANAPHYLAXIS ACTION PLAN

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Parent Completes

Student Name:	DOB:	Student Weight:
Allergic to:	Grade/Teacher:	
Asthmatic: ❐ Yes *(Higher risk for severe reaction)* ❐ No	Fam. hx. allergies:	
Date of Last Reaction: ❐ N/A	Went to Hospital? ❐ Yes ❐ No ❐ N/A	
Symptoms (hives, difficulty breathing, etc):		
PHYSICIAN: Hx of anaphylaxis is: ❐ Actual ❐ Potential	Allergy Testing: ❐ Serum ❐ Skin ❐ N/A	

<---------- To be completed by Physician. ---------->

STEP ①: Treatment

Symptoms of Allergic Reaction: ⧫ *Potentially life-threatening. Severity of symptoms can change quickly.*	**Give checked Medication** *To be determined by physician*	
If a food allergen has been ingested, but no symptoms occur:	❐ epinephrine	❐ antihistamine
Mouth - itching, tingling, swelling of lips, tongue, mouth:	❐ epinephrine	❐ antihistamine
Skin - hives, itchy rash, swelling of the face or extremities:	❐ epinephrine	❐ antihistamine
Gut - nausea, abdominal cramps, vomiting, diarrhea:	❐ epinephrine	❐ antihistamine
Throat⧫ - tightness of throat, hoarseness, hacking cough:	❐ epinephrine	❐ antihistamine
Lungs⧫ - shortness of breath, repetitive coughing, wheezing:	❐ epinephrine	❐ antihistamine
Heart⧫ - weak/thready pulse, low BP, fainting, pale/blueness:	❐ epinephrine	❐ antihistamine
Other⧫ - (fill in)	❐ epinephrine	❐ antihistamine
If reaction is progressing (several of the above areas affected), give:	❐ epinephrine	❐ antihistamine

Medication Dosage:*

Epinephrine injected intramuscularly (*CHECK ONE*):

❐ EpiPen ❐ EpiPen Jr.
❐ Auvi-Q 0.3 mg ❐ Auvi-Q 0.15 mg

IF SYMPTOMS PERSIST
REPEAT DOSE IN ______ MINUTES.

Antihistamine (med/dose/route): ____________________
____

Other (med/dose/route): ____________________
____

Medication Sequence* (*Select One Option*):

❐ Give epinephrine only
❐ Give antihistamine & epinephrine at the same time
❐ Give antihistamine first, observe for further symptoms and give epinephrine *if needed*.

**IF ANTIHISTAMINE AND EPINEPHRINE ARE ORDERED, DELEGATES WILL SKIP THE ANTIHISTAMINE AND ADMINISTER EPINEPHRINE IMMEDIATELY. DELEGATES MAY ONLY ADMINISTER EPINEPHRINE.*

Medication Self-Administration† (*Select One Option*):

❐ This student has been trained and is capable of self-administration of:
  ❐ Epinephrine - single dose unit
  ❐ Epinephrine & antihistamine - single dose units
❐ This student is NOT capable of self-administration of the medications above.

† *Note: under NJ state law, orders for antihistamine alone cannot be self-administered.*

✍ *Physician's Sig.*: ______________________________ Date: __________

Stamp of Physician: ______________________________ Phone: __________

To Be Completed by Parent

Medication Self-Administration (*IF APPLICABLE*):

I give permission for my child to self administer the above-mentioned medication. I and my student assume responsibility to ensure that this medication is in his/her possession prior to participating in any practice, event and/or field trip during the academic school day. Long Pond School and its employees shall be held harmless against injury or claims that arise as a request of the pupil's self-administration of medication.

Parent/Guardian Signature ***IF APPLICABLE*** ________________________________ Date: _______

STEP ②: Emergency Calls

1. Call 911. *State that an allergic reaction has been treated, and that additional epinephrine and advanced life support may be needed.*

2. Call Parent(s)

   Parent/Guardian 1: ____________________ Cell Phone: ____________________

   Work Phone: ____________________ Home Phone: ____________________

   Parent/Guardian 2: ____________________ Cell Phone: ____________________

   Work Phone: ____________________ Home Phone: ____________________

If parent(s)/guardians(s) cannot be reached, do not hesitate to medicate or have child transported via rescue squad to nearest emergency medical facility!

3. Call emergency contacts if parent(s)/guardian(s) unreachable:

   Name/Relationship 1: ____________________ Phone: ____________________

   Name/Relationship 2: ____________________ Phone: ____________________

4. Notify physician: ____

Parent/Guardian Authorizations:

I, ________________________, give permission for the administration of the prescribed medication as directed by the physician to my child ________________________. I also authorize delegates trained by the school nurse to administer the epinephrine if the school nurse is unavailable and the student is unable to self-administer. I understand that antihistamines may not be given by a delegate, and that *in the absence of the school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.*

I further acknowledge and understand the following:

▶ If the procedures specified in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" are followed, the district or nonpublic school shall have no liability as a result of any injury arising from the administration of a pre-filled, auto-injector mechanism containing epinephrine to the pupil and that the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of a pre-filled auto-injector mechanism containing epinephrine to the pupil.

▶ I will provide the school with the prescribed medication and will replace it when it is expired.

▶ I give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and the above-mentioned medications. In addition, I understand that this information will be shared with school staff on a need-to-know basis.

▶ This permission is effective for the school year for which it is granted and will be renewed for each subsequent school year upon fulfillment of the requirements stated in the N.J.S.A. 18A:40-12.6.

Parent/Guardian Signature: ________________________________ Date: ______

Parent Completes

Individualized Healthcare Plan: Anaphylaxis (page 1)

Student Name: ______________________ Date: __________

DOB: __________ Class/Grade: ______________________

TO BE COMPLETED BY SCHOOL NURSE

ASSESSMENT	NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTIONS	STUDENT OUTCOME
Medical documentation of allergy to: __________ __________ __________ __________ Prescribed med(s): ❐ Antihistamine ❐ Epi-Pen Jr. ❐ Epi-Pen *(See Allergy Action Plan for full details.)* BP: __________ Temp: __________ Pulse: __________ Resp: __________ Other:	❐ Potential for life threatening reaction related to ineffective airway clearance and decreased cardiac output. ❐ Potential for knowledge deficit related to: ❐ Allergen ❐ Symptoms of allergic reaction ❐ Emergency Care Plan ❐ Effective therapeutic regimen management related to: ❐ Ability to seek help from others ❐ Ability to self-medicate (when appropriate)	❐ Avoid contact with allergen or source of anaphylactic reaction. ❐ Identify symptoms of allergic reaction. ❐ Participate in development and implementation of healthcare plan at school. ❐ Be safe in all school environments. ❐ Know when and how to seek help. ❐ Develop self-medication skills when appropriate. ❐ Prevent allergic reactions from occurring.	❐ Provide necessary health counseling opportunities for student to participate in self-care (depending on student's cognitive and/or physical ability) ❐ Review symptoms & sources of allergen(s). ❐ Review treatment methods, including how/when to seek assistance from school staff and classmates. ❐ Teach proper technique of self-administration of epinephrine (if indicated by parent & HCP). ❐ Monitor school environment for potential allergens and environmental triggers. Notify custodial staff as appropriate. ❐ Teach *all* students not to share food. ❐ Maintain current medical orders, consents, release of records and supply of medication. ❐ Ensure all school staff (including bus driver if appropriate) complete anaphylaxis in-service. ❐ Develop Emergency Care Plan with treatment guidelines (mild - severe). ❐ Identify and train volunteer staff for administration of EpiPen as EpiPen Delegate(s). ❐ If food allergen, ensure student brings lunch from home ***or*** parent has spoken with Maschio's dietitian re: safe menu selections. ❐ Distribute list of approved foods for classroom celebrations to all parents and teachers. Ensure Homeroom Parents allow only these products.	❐ Student will identify his/her symptoms of allergic reaction (from mild to severe) and share information with school personnel. ❐ Student will actively participate in healthcare management and ECP at school. ❐ Student will understand medication administration and return demonstration (if indicated by parent & physician).

Individualized Healthcare Plan: Anaphylaxis (page 2)

			❑ Make any field trip and extracurricular activity modifications that are needed. ❑ Maintain epinephrine in secure, unlocked location. ❑ Encourage student to forgo using water fountain; instead have parent provide w/ personal water bottle. ❑ Encourage student to wear identification bracelet/necklace, to be obtained by parent. ❑ Document each episode of reaction & severity.	

Additional Notes: ______________________________

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Parent/Guardian Statement: *I have read this plan and agree to its implementation.*

Parent/Guardian Signature: ______________________________ Date: __________

Student Signature (if age-appropriate): ______________________________ Date: __________

Nurse Signature: ______________________________ Date: __________

Annual IHP Review (for subsequent years):

Parent/Guardian Sig.:	Date:	*Parent/Guardian Sig.*:	Date:
Student Sig. (if appropriate):	Date:	*Student Sig. (if appropriate)*:	Date:
Nurse Sig.:	Date:	*Nurse Sig.*:	Date:
Parent/Guardian Sig.:	Date:	*Parent/Guardian Sig.*:	Date:
Student Sig. (if appropriate):	Date:	*Student Sig. (if appropriate)*:	Date:
Nurse Sig.:	Date:	*Nurse Sig.*:	Date:

✳NON SELF-CARRY & STOCK EPIPENS ARE LOCATED IN THE MAIN ENTRY HALLWAY ✳ School Year ________

Andover Regional School District Allergy Emergency Care Plan: For Non-Medical Staff of Long Pond School

Parent Completes

Student: ______________________ DOB: __________ Grade/Teacher: ______________

Severe Allergy to: ______________________ Asthmatic: ❒ Yes ❒ No Weight: ________

Transpo. to/from school - AM: ______________ PM: ______________ "Aftercare": ❒ N/A ❒ AM ❒ PM

Parent/Guard. 1: ______________ Cell: __________ W: __________ H: __________

Parent/Guard. 2: ______________ Cell: __________ W: __________ H: __________

Emerg. Cntct. 1: ______________ Cell: __________ W: __________ H: __________

Physician Name: ______________________ Physician Phone: ______________

SEVERE SYMPTOMS	**STAFF ACTIONS**	
of Allergic Reaction ❗ *Epinephrine needed for ANY of these*	*...WHEN NURSE/EPI-PEN DELEGATE IN BUILDING:*	*...IF NURSE/EPI-PEN DELEGATE **UNAVAILABLE***
• Short of breath, wheezing, coughing • Pale, clammy, blue, faint, dizzy • Throat tightness, hoarse, trouble breathing/swallowing • Swelling of tongue and/or lips • Hives all over body; widespread redness • Severe vomiting or diarrhea • Sense of impending doom, anxiety, confusion	• Call the nurse (**x 303**) to come to the student. *State: location, student name, allergic reaction.* • Remain with and reassure student. • Nurse will administer medication(s). • In absence of Nurse, **EpiPen Delegate will administer EpiPen ONLY, not Benadryl or other meds** • If EpiPen is given, call 911 immediately and then call parent.	• Call 911, state student has allergic reaction and epinephrine and advanced life support are needed. • Notify Administrator & parent • Remain with and reassure student until paramedics arrive. • If breathing stops, CPR-certified staff gives CPR until EMS arrives. • *A school staff should go in ambulance if guardian not present*

MILD SYMPTOMS of Allergic Reaction	**STAFF ACTIONS** *...WHEN NURSE IN BUILDING:*	*...IF NURSE UNAVAILABLE:*
✳ *More than 1 of these symptoms is a SEVERE reaction; treat as above* • Itchy/runny nose, sneezing • Itchy mouth • A few hives, mild itching • Mild nausea/discomfort	• Stop activity immediately: ***never ask an allergic student to wait until the end of a lesson or class.*** • Send student to nurse with a buddy; ***never send student alone!*** • Nurse will assess and give meds. • Nurse will observe for relief of symptoms and contact parent and/or call 911 as needed.	• Notify Administrator and parent. • Parent/guardian (if available) may come to school to administer medication and/or take child home for care. • *If parent/guardian and emergency contacts cannot be reached and symptoms persist or worsen, do not hesitate to call 911.*

Bus Plan: (1) Pull over, (2) Call 911, (3) Stay with student, (4) Notify School, (5) Notify Parent

Dosage: ❒ EpiPen ❒ Epipen Jr.	Food Allergy Lunch Table: ❒ Yes ❒ No	Water Fountain Use: ❒ Yes ❒ No

Names of Delegate(s):

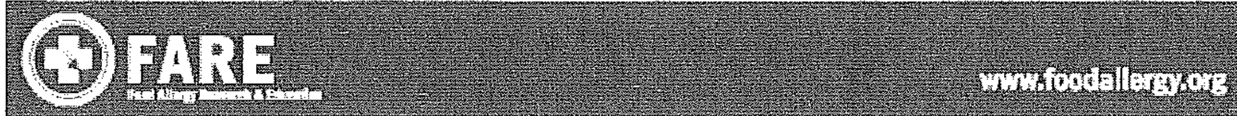
Parent Signature: ______________________ Date: __________

Nurse Signature: ______________________ Date: __________

School Year ___________

General Prevention Tips:

- No sharing of food.
- Frequent hand-washing/cleaning of desks and countertops is important.
- Be particularly vigilant on special days: field trips, parties, and other special events.
- Notify substitutes of student allergy and keep this ECP in substitute folder.



For a suspected or active food allergy reaction:

FOR ANY OF THE FOLLOWING **SEVERE SYMPTOMS**

- LUNG: Short of breath, wheezing, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Significant swelling of the tongue and/or lips
- SKIN: Many hives over body, widespread redness
- GUT: Repetitive vomiting or severe diarrhea
- OTHER: Feeling something bad is about to happen, anxiety, confusion

OR MORE THAN ONE **MILD SYMPTOM**

- NOSE: Itchy/runny nose, sneezing
- MOUTH: Itchy mouth
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort

⇨ Nurse or EpiPen Delegate
⇨ will give EpiPen & call 911

For School Staff: *I acknowledge that I have received a copy of the Allergy ECP for student ______________________________.*
If I am a teacher, I agree to keep a copy of this document in my substitute folder.

Name/Job Title: ______________________ *Signature*: ______________________ Date: __________

Name/Job Title: ______________________ *Signature*: ______________________ Date: __________

Name/Job Title: ______________________ *Signature*: ______________________ Date: __________

Name/Job Title: ______________________ *Signature*: ______________________ Date: __________

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