FAUQUIER COUNTY PUBLIC SCHOOLS HEALTH CAREPLAN FOR SEVERE ALLERGY PART 1

STUDENT NAME:_____ **DOB:**_____ **DATE:**_____

ALLERGIC TO:_____

PHYSICIAN ORDERED MEDICATIONS

1. Antihistamine: ☐ NONE OR ☐ Benadryl/Diphenhydramine HCL:_____ mg/Other:_____
2. Inhaler: ☐ NONE OR ☐ Medication_____ Dose_____
3. Epinephrine Auto Injector (Epi-pen) 0.30mg ☐ OR Epinephrine Auto Injector JUNIOR 0.15mg ☐
4. Repeat Epi-pen: ☐ NO or ☐ YES, specify when repeat dose to be given_____

SYMPTOM	GIVE CHECKED MEDICATION	
SEVERE SYMPTOMS following allergen exposure MOUTH: swelling lips/tongue/throat LUNGS: shortness of breath/wheezing/repetitive cough CIRC: weak pulse/low BP/fainting/dizziness/confusion SKIN: widespread hives/flushing or pale/blue skin GUT: severe/repetitive vomiting/diarrhea	☐ **Epi-pen**	☐ **Antihistamine**
MILD SYMPTOMS present from **SINGLE SYSTEM** MOUTH/NOSE: itchy mouth or itchy/runny nose SKIN: a few hives, mild itch GUT: mild nausea/discomfort	☐ **Give Antihistamine. Stay with student and alert guardian. Watch closely for changes. If symptoms become severe, give Epi-pen per order.**	
MILD SYMPTOMS from **MULTIPLE SYSTEMS**	☐ **Epi-pen**	☐ **Antihistamine**

SPECIAL CIRCUMSTANCE: Due to severity of allergy history, give Epi-pen upon allergen exposure (allergen confirmed eaten/student stung if bee allergy) even if **NO ALLERGY SYMPTOMS PRESENT.** YES ☐ NO ☐

PHYSICIAN:_____ / _____ / _____ / _____
Printed Name Signature Phone Date

1. Note time medications given. **CALL 911** if Epi-pen given. Notify guardian and school administrator.
2. If Antihistamine given for mild symptom only, remain with student and notify guardian. Watch closely for changes as symptoms may worsen and become severe.
3. If symptoms severe, lay student flat, raise legs, and keep warm. Sitting up may help student with breathing difficulties.

PERMISSION TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE/INHALER/ANTIHISTAMINE

I certify that this child has potential for severe allergic reaction and that child has been judged capable of carrying and self-administering the above medications for allergic reaction.

PHYSICIAN SIGNATURE_____ **Self-carry/administration permission granted YES** ☐ **NO** ☐

I give consent for my child to carry and self-administer the above ordered medications. My child has been instructed on the recognition of symptoms and the safe/effective use of the ordered medications. My child understands the hazards of sharing medications and has agreed to refrain from doing so. My child knows to notify school staff if medications are used. I will not hold the school board or its employees liable for any negative outcome from my child self-carrying or administering the medications. I understand that this permission may be revoked by the principal to maintain safety.

GUARDIAN SIGNATURE_____ **PRINTED NAME**_____ **DATE**_____
NURSE: ORDER/MEDICATION RECEIPT_____ **DATE**_____

Fauquier County Public Schools Health Care Plan for Severe Allergy-Part 2

STUDENT NAME:_____ **DOB:**_____ **DATE:**_____

Date/Description of Last Reaction:_____

Has Epinephrine Been Used in the Past/Explain_____

PARENT/GUARDIAN PHONE (H)_____ **(W)**_____ **(C)**_____

PARENT/GUARDIAN PHONE (H)_____ **(W)**_____ **(C)**_____

BUS PROCEDURES

1. Emergency Transportation Plan: ☐ Given to Guardian ☐ Completed/Returned by Guardian
2. Student will sit at the front of the bus: ☐ YES ☐ NO

FIELD TRIP PROCEDURES

1. The teacher/nurse will discuss field trips with guardian in advance. Guardian encouraged to accompany student on the trip. If cannot attend and student does not have self-administration permission, responsible teacher will carry/ administer medications as ordered, after receiving instruction on the use of the medications from the nurse.
2. The student will remain with the teacher or guardian during the entire trip: ☐ YES ☐ NO

CLASSROOM

1. Teachers will be notified of allergy. Teacher will review classroom projects to avoid specified allergens.
2. Other:_____

ATHLETICS / EXTRA-CURRICULAR ACTIVITIES

1. Parents are responsible for notifying coach/activity sponsor of student's allergy if student stays after school for athletics/extra-curricular activities/clubs. School nurses are only available during regular school hours.

STUDENTS WITH FOOD ALLERGIES-PLEASE CHECK ALL BOXES THAT APPLY

1. ☐ Student will only eat food provided by guardian.
2. ☐ Student allowed to eat from school menu, make own food choices, and will seek assistance from cafeteria/clinic staff as needed.
3. ☐ Alternative snacks will be provided by guardian to be kept in classroom/clinic.
4. ☐ Guardians will be told of planned lessons/parties/activities involving food as early as possible.
5. ☐ Student will have NO SEATING RESTRICTIONS in cafeteria.
6. ☐ Student requires following cafeteria seating_____
7. Other:_____

Signature gives permission for the principal's designee to administer the ordered medications on Part 1 of this Health Care Plan and to contact the ordering health care provider if necessary to discuss this allergy plan.

PARENT/GUARDIAN SIGNATURE_____ **PRINTED NAME**_____ **DATE**_____

ORDERS RECEIVED/REVIEWED BY_____ **DATE**_____

Notification (initial/date): Admin_____ Transport_____ Teachers_____ Cafeteria_____