

**BERWY NORTH PUBLIC SCHOOL DISTRICT 98 ALLERGY
MEDICAL MANAGEMENT PLAN**

PART I TO BE COMPLETED BY PARENT

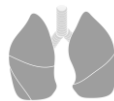
Student _____ ID # _____ D.O.B. _____ School _____

ALLERGY TO _____ Teacher/Grade _____

Asthmatic Yes* No *Higher risk for Severe Reaction

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

**FOR ANY OF THE FOLLOWING
SEVERE SYMPTOMS:**



Lung

Shortness of
Breath, wheezing
repetitive cough



Heart

Pale or bluish
skin, faintness,
weak pulse, dizziness



Throat

Tight or hoarse
throat, trouble
breathing or
swallowing



Mouth

Significant
swelling of the
tongue or lips



Skin

Many hives over
Body, widespread
redness



Gut

Repetitive
vomiting, severe
diarrhea



Other

Feeling
something bad is
about to happen,
anxiety, confusion

**Or a
Combination**

of symptoms
from different
body areas

1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
 - Antihistamine
 - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



Nose

Itchy or
Runny nose
Sneezing



Mouth

Itchy Mouth



Skin

A few hives
mild itch



Gut

Mild
nausea or
discomfort

FOR MILD SYMPTOMS FROM MORE THAN
ONE SYSTEM AREA, GIVE EPINEPHRINE

FOR MILD SYMPTOMS FROM A SINGLE
SYSTEM AREA, FOLLOW THE DIRECTIONS
BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Dose:

0.1 mg IM 0.15 mg IM 0.3 mg IM

Student May Self Carry Yes No

Antihistamine _____

Dose/Frequency: _____

Other (e.g. inhaler-bronchodilator if wheezing):

I request designated staff to administer the medication as prescribed by the licensed provider above. I certify that I have legal authority to consent to the administration of medication at school. I authorize the school nurse to communicate with the licensed prescriber regarding the administration of this medication.

Parent/Guardian Signature

Telephone

Date

Licensed Health Care Provider
Print

Licensed Health Care Provider
Signature

Telephone

Date

**BERWY NORTH PUBLIC SCHOOL DISTRICT 98 ALLERGY
MEDICAL MANAGEMENT PLAN**

PART III

TO BE COMPLETED BY PARENT

History and Current Status

1. How many times has student had a reaction? Never Once, Age ____ More than once, explain:

2. Explain their past reaction: _____
3. Symptoms: _____
4. What are the **early** signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say) _____

Treatment

1. Has your student previously used treatment or medication for their allergy? No Yes, Age _____
Treatment/medication used _____
2. How effective was the student's response to previous treatment? _____
3. Was there an emergency room visit? No Yes, explain _____
4. Was the student admitted to the hospital? No Yes, explain _____
5. Please describe any side effects or problems your child had in using the suggested treatment: _____

Self Care

1. Is your student able to monitor and prevent their own exposures? No Yes
 2. Does your student:
 - a. Know what foods to avoid No Yes
 - b. Ask about food ingredients No Yes
 - c. Read and understand food labels No Yes
 - d. Tell an adult immediately after an exposure No Yes
 - e. Wear a medical alert bracelet, necklace, watchband No Yes
 - f. Tell peers and adults about the allergy No Yes
 - g. Firmly refuses a problem food No Yes
 3. Does your child know how to use emergency medication? No Yes
 4. Has your child ever administered their own emergency medication? No Yes
- Explain any of the above: _____

Parental Permission for Student to Self-Carry Epinephrine No Yes

If yes, I hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize the School District to allow my child to self-administer his or her lawfully prescribed Asthma Inhaler/Epinephrine medication during the following: (1) while in school; (2) while at a school-sponsored activity; (3) while under the supervision of school personnel; and (4) before or after normal school activities.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma medication. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self-administration of said medication.

Parent/Guardian Signature

Date

PART III TO BE COMPLETED BY SCHOOL NURSE

Student _____ ALLERGY _____

ACTION PLAN CHECKLIST FOR SCHOOL PERSONNEL

- Allergy Action Plan Part I and II, complete **yes** **no**
- Antihistamine medication authorization complete **yes** **no**
- Epinephrine medication authorization complete **yes** **no**
- Medication self carried **yes** **no**

- Medication stored: _____, _____
(Location) (Location)
- Expiration date of medication (s): _____, _____
(Epinephrine) (Antihistamine)

- Copies of plan provided to: Educational **yes** **no** **n/a**
Athletic **yes** **no** **n/a**
- Notify of specific allergy: Food Service **yes** **no** **n/a**
- Staff trained in medication Administration **yes** **no**

PART IV TRAINED STAFF IN ADDITION TO SCHOOL NURSE

Name _____ Date _____ Location _____

Name _____ Date _____ Location _____

The EpiPen is self-injecting. It is used in cases of anaphylaxis of any cause.



Directions for use:

- Remove gray safety cap and grasp EpiPen with your fist
- Press the black end of EpiPen against outer thigh until you hear a click and needle is released. EpiPen is designed to be used through clothing if necessary.
- **Maintain EpiPen in position for 10 seconds.**
- Remove EpiPen, call 911 for immediate medical attention
- Carefully place the used auto-injector (without bending the needle), needle-end first, into the storage tube of the carrying case that provides built-in needle protection after use. Then screw the cap of the stored tube back on completely and give to the emergency responder to dispose of in the emergency room.

Full Allergy Action plan has been reviewed.

School Nurse

Date

Adapted from: Virginia Department of Health, Virginia Department of Education (2004) *Guidelines for Specialized Health Care Procedures* and from the Office of Catholic Schools Diocese of Arlington