ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS/504

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Cheney SD, Student Support Services, 12414 S. Andrus Rd, Cheney, WA 99004  FAX: 509-559-4517

ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS

ALLERGY TO: ___________________________________________________________

Epinephrine auto-injector(s) (EAI) location
☐ Office
☐ Backpack
☐ On person
☐ Other:__________________________

Inhaler(s) location
☐ Office
☐ Backpack
☐ On person
☐ Other:__________________________

Anaphylaxis (Severe allergic reaction) is an excessive reaction by the body to combat a foreign substance that has been eaten, injected, inhaled or absorbed through the skin. It is an intense and life-threatening medical emergency. Do not hesitate to give EAI and call 911.

USUAL SYMPTOMS of an allergic reaction: (please check those that are known/history for student)

MOUTH (Lips, Tongue):
☐ Itching
☐ Tingling
☐ Swelling

THROAT:
☐ Sense of tightness
☐ Hoarseness
☐ Hacking cough

GUT:
☐ Nausea
☐ Stomach ache/cramps
☐ Vomiting
☐ Diarrhea

LUNG:
☐ Shortness of breath
☐ Repetitive coughing
☐ Wheezing

SKIN:
☐ Hive
☐ Itchy Rash
☐ Swelling of the face/extremities

HEART:
☐ Thready pulse
☐ Passing out/Fainting
☐ Blueness
☐ Pale

GENERAL:
☐ Panic
☐ Sudden Fatigue
☐ Chills
☐ Fear
☐ Impending doom

This Section to be Completed by a Licensed Healthcare Provider (LHP)

If student has symptoms or you suspect probable exposure (is stung, eats food he/she is allergic to, or exposed to allergen)

1. Administer Epinephrine auto-injector (EAI)
    ☐ 0.3 mg
    ☐ 0.15 mg (Jr)
    ☐ May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived

2. Call 911 – Advise EMS that Epinephrine has been administered

3. Stay with student

4. After EAI administered, administer __________________________ (antihistamine) ______________ (mg)

5. If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EAI, administer

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®)
☐ Levalbuterol 2 puffs (Xopenex®)
☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)
☐ Other __________________________
    ☐ May repeat every _______ minutes as needed for symptoms

6. Notify school nurse and parent/guardian

7. A Student given an EAI must be monitored by medical personnel or a parent and may NOT remain at school

☐ Student may carry EAI and/or antihistamine
☐ Student may self-administer EAI and/or antihistamine
☐ Student may carry and self-administer Inhaler

SIDE EFFECTS of medication(s):

EAI: increased heart rate. __________________________

Antihistamine: sleepy

Albuterol/Levalbuterol: increased heart rate, shakiness.

* * * * * If student has a food allergy, please complete Request for Special Dietary Accommodations and Attachment A: Foods to be Omitted and Substituted form * * * * *
Anaphylaxis Care Plan – Part 2 – Parent/Guardian (STUDENT): ____________________________

Food Allergy Accommodations
☐ Foods and alternative snacks will be approved and provided by parent/guardian
☐ Notify parent/guardian of any planned parties as early as possible
☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens

Student is able to make their own food decisions ☐ Yes ☐ No
When eating, student requires ☐ Specified eating location, where _____________________________
☐ No restrictions ☐ Other _____________________________

Transportation staff should be alerted to student’s allergy
• Student carries Epinephrine auto-injector (EAI) on the bus/transportation ☐ Yes ☐ No
• EAI can be found ☐ On person ☐ Other (specify) _____________________________
• Student will sit at front of the bus ☐ Yes ☐ No
• Other (specify) _____________________________

Field Trip/Extracurricular Activity: EAI must accompany student during any off campus activity
• The student must remain with the teacher or parent/guardian during the entire field trip ☐ Yes ☐ No
• Field trip staff must be trained to medication and health care plan (health care plan must also accompany student)

Other Accommodations
☐ Does student need other classroom, school activity, or recess accommodations ☐ Yes ☐ No If yes, contact the school counselor or 504 coordinator

EMERGENCY CONTACTS

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- My child may carry and is trained to self-administer their EAI ☐ Yes ☐ No Provide extra for office ☐ Yes ☐ No
- My child may carry and is trained to self-administer their rescue inhaler ☐ Yes ☐ No Provide extra for office ☐ Yes ☐ No
- My child may carry their EAI (needs assistance to administer) ☐ Yes ☐ No

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care plan, it is the parent/guardian’s responsibility to contact the school nurse.
- It is the parent/guardian’s responsibility to alert all other non-school programs of their child’s health condition.
- Medical information may be shared with school staff working with my child and EMS, if they are called.
- I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatment in accordance with the licensed healthcare provider’s (LHP) instructions.
- This is a life-threatening care plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child’s severe allergy between the LHP office and the school nurse.
- I have reviewed and agree with this health care plan/504 and medication/treatment order.

Parent/Guardian Signature ____________________________ Date _____________
- I have demonstrated the correct use of the epi pen/antihistamine/inhaler to the medical provider and/or school nurse.
- I agree never to share my medication with another person or use it in an unsafe manner.
- I agree that if I self-administer medication, I will report to an adult at school if the nurse is not available or present.

Student Signature ____________________________ Date _____________

For School District Nurse Only
A Registered Nurse has completed a nursing assessment and developed this Anaphylaxis Care Plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication ordered above: ☐ Yes ☐ No If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: ☐ Yes ☐ No

Device(s) if any, used ____________________________ Expiration date(s) ____________________________

Registered Nurse Signature ____________________________ Date _____________ Phone ____________________________

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.