Allergy & Anaphylaxis Plan

RN verified _____

Student_____ Grade_____ Date_____

Date of Birth_____ School_____ Teacher_____

Emergency Contacts

Name_____ Number_____ Relationship_____

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Allergy to: _____

Describe known signs or symptom from any previous allergic reaction:

_____

Is Allergy (check all that apply):

- ☐ Contact
- ☐ Airborne
- ☐ Ingestion

Asthma:

- ☐ Yes (higher risk for severe reaction)
- ☐ No

☐ My student has a mild reaction and if my student would ingest _____ please call parent. **Medication will not be provided for the school at this time. I understand that if the reaction appears life threatening, 911 will be called first.**

For any MILD symptoms from a SINGLE SYSTEM:	
• Nose: Itchy/runny nose, sneezing • Mouth: Itchy mouth • Skin: A few hives, mild itch • Gut: Mild nausea/discomfort	1. Antihistamine may be given, if ordered by a provider. 2. Stay with person and monitor for changes. 3. If symptoms worsen or involve more than one system area, give epinephrine if available and call 911. 4. Alert emergency contacts.

For any SEVERE SYMPTOMS after suspected or known ingestion: (one or more of the following)	
• 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, severe diarrhea • Other: Feeling something bad is about to happen, anxiety, confusion	1. Inject Epinephrine immediately 2. Call 911 3. Consider giving additional medications: a. Antihistamine b. Inhaler (if wheezing) 4. Lay person flat with legs elevated. 5. If symptoms don't improve or worsen after 5 minutes, give second dose of epinephrine if available. 6. Alert emergency contacts.

Medications/Doses To Be Given At School (To Be Completed By Provider)

Epinephrine Brand (Rx label attached):_____

Epinephrine Dose (inject IM): ☐ 0.15 mg IM ☐ 0.3 mg IM Expiration Date:_____

Antihistamine Brand or Generic: _____

Antihistamine Dose:_____ Route: _____ Expiration Date:_____

Other (e.g., Inhaler):_____ Dose: _____ Route:_____ Expiration Date:_____

Comments:_____

All medications administered by AASD staff are only available to students during school hours (7:30 a.m.- 4:00 pm), must not be expired, and in a properly labeled pharmacy box/bottle. Ask your pharmacy for any needed additional labels or containers.

Parent Consent For Management Of Health Condition While At School

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature_____Date_____

Provider Information/Consent (Provider only needs to sign if student has prescription medication to be given at school.)

Print Name of Provider_____Clinic Name_____

Phone Number_____Fax Number_____

Address_____

Signature of Provider_____ Date_____

I agree to allow my student to transport the medication package (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year. *Controlled substances may not be transported by students.* ☐ Yes ☐ No

**Note to Health Care Provider-This document serves as medication and treatment orders.*