SEVERE ALLERGY/ANAPHYLAXIS MEDICATION ORDER AND HEALTH HISTORY

School Year _____

STUDENT'S LAST NAME:	**STUDENT'S FIRST NAME:**	**Date of Birth:**
Grade:	**School:**	

Prior to attendance at school, each child with a life-threatening health condition shall present a medication or treatment order addressing the condition. A life-threatening health condition means a condition that will put the child in danger of death during the school day if a medication and/or treatment order and a nursing plan are not in place. Following submission of the medication or treatment order, a nursing plan shall be developed by the school nurse. Medication and treatment orders are required to be completed each school year. (WAC 392-380-045, RCW 28A.210.320.

This Section To Be Completed By A Licensed Healthcare Provider (LHCP):

When a school nurse is NOT AVAILABLE trained staff will administer epinephrine without delay if a student has a symptom or suspected exposure to the allergen as indicated in Student's Emergency Care Plan (ECP). A student given an Epinephrine Auto Injector must be monitored by medical personnel or a parent and may NOT remain at school.

Severe allergy to: _____

History of Asthma: ☐ Yes (Indicates higher chance of severe reaction. **Asthma Medication Order required for inhaler use at school**.)
☐ No

History of Anaphylaxis: ☐ Yes, Date of last reaction: _____ ☐ Skin Testing Indicates Allergy
☐ No

If a student has symptoms or you suspect exposure (i.e., is stung, eats food allergen, or is exposed to allergen):

1. Give Epinephrine Auto Injector (EAI) ☐ 0.3 mg ☐ Jr. 0.15 mg

   ☐ May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived. Document time medications were given and alert EMS when they arrive.
2. Stay with student
3. CALL 911 - Advise Emergency Medical Services that student has been administered Epinephrine
4. Notify parents and school nurse
5. After Epinephrine Auto Injector administered, administer Benadryl® or antihistamine _____ (ml/mg/cc)
6. If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction, after Epinephrine Auto Injector and antihistamine, administer:
   - ☐ Albuterol (Pro-air®, Ventolin HFA®, Proventil®) _____ puffs
   - ☐ Levalalbuterol (Xopenex®) _____ puffs
   - ☐ Other: _____
7. Permission to carry & self-administer medication:
   - ☐ Student has been instructed and is capable of carrying & self-administering EAI
   - ☐ Student has been instructed and is capable of carrying & self-administering MDI

(LHCP) PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY

Disability: Potential anaphylaxis if food ingested. **Major life activity affected:** Potential shut down of multiple body symptoms leading to death**.**
How disability restricts student diet: Student must not eat food containing allergen(s).

FOODS TO OMIT: _____

Suggested general substitutions: _____

LHCP Name:	LHCP Signature	Date
Address:	Telephone #:	Fax #:

Medication order is valid for duration of current school year which includes summer school.

PARENT/GUARDIAN MUST SIGN PAGE 2

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SECTION TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

Student's Name: _____ **Grade:** _____

Parent/Guardian Name: _____ **Phone #:** _____

Identify student's specific response to the allergen:

☐ MOUTH--Itching, tingling, or swelling of the lips, tongue, or mouth

☐ SKIN--Hives, itchy rash, and/or swelling about the face or extremities

☐ THROAT--Tight or hoarse throat, trouble breathing or swallowing

☐ GUT--Nausea, stomachache/abdominal cramps, vomiting and/or diarrhea

☐ LUNG--Shortness of breath, repetitive coughing, and/or wheezing

☐ HEART--"Thready" pulse, "passing out", fainting, blueness, pale

☐ GENERAL--Panic, sudden feeling of impending doom

☐ OTHER-- _____

History and Current Status

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, explain: _____

When was the last reaction? _____

The allergy reactions are: ☐ staying the same ☐ getting worse ☐ getting better

Symptoms

What are the signs and symptoms of your student's allergic reaction? (Be specific, include things the student might say.)

_____

How quickly do symptoms appear after exposure to the allergen(s)? (seconds, minutes, hours, days) _____

My student may carry and self-administer prescribed EAI with LHCP approval:	☐ Yes	☐ No	Provide extra for office?	☐ Yes	☐ No
My student may carry and self-administer prescribed asthma inhaler with LHCP approval:	☐ Yes	☐ No	Provide extra for office?	☐ Yes	☐ No

- I request this medication to be given as ordered by the licensed healthcare provider (LHCP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHCP/medical office staff about this plan and medication.
- I understand that the medication may not be administered by a nurse but may be administered by school staff trained and supervised by an RN.
- I release school staff from any liability in the administration of this medication at school.
- I understand that a life-threatening health care plan can only be discontinued, in writing, by the prescribing LHCP.
- Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHCP.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- Permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer the ordered medications.
- I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions.

Parent/Guardian Signature: _____ **Date:** _____

Student Signature – 18 years or older signing on own behalf (RCW 26.28.015 or RCW 70.02.130):

_____ **Date:** _____

For School District Nurse Use Only

This student has demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication.

This student may carry and self-administer their medication: ☐ Yes ☐ No

Device(s) if any, used: _____ **Expiration date(s):** _____

_____ _____

Registered Nurse Signature **Date**

Epinephrine auto-injector (EAI) location:	☐ Office	☐ BACKPACK	☐ ON PERSON	☐ OTHER: _____
Inhaler(s) location:	☐ Office	☐ BACKPACK	☐ ON PERSON	☐ OTHER: _____

Date EAP Created: _____

IEP ☐ **504** ☐

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