LIFE-THREATENING ALLERGY/504 PLAN

ISSAQUAH SCHOOL DISTRICT 411

Student Name:	DOB:	
School:	School Year:	Grade:
Advisor:	Transportation: ☐ Walker ☐ Car ☐ Bus Rider – Bus number:	

* EMERGENCY ACTION PLAN*

Medication Orders *– This section to be completed by a* ***LICENSED HEALTHCARE PROVIDER (HCP)*****:**

Severe Allergy to	**Specific Symptoms**	**Date of Last Reaction**

Asthma: ☐ **Yes** (High Risk for Severe Reaction) ☐ **No**

If student has symptoms or you suspect exposure to their allergen:

1) Give Epinephrine auto-injector ☐ **0.15 mg** ☐ **0.3 mg** injected in outer thigh
   Repeat dose of Epinephrine, if available ☐ Yes ☐ No If "Yes", when:_____
2) Adult should stay with student.
3) CALL 911 – and report that Epinephrine has been administered for an allergic reaction
4) Note time of reaction. Note time medication given
5) Notify school nurse and parent/guardian
6) **After** Epi auto-injector is given, give Antihistamine
   ☐ **antihistamine:** _____ **Dose:** _____ **by mouth.**
7) If student has a history of asthma and is experiencing wheezing, shortness of breath, chest tightness with allergic reaction:
   After Epi auto-injector and antihistamine, give: **Albuterol -** ☐ **2 puffs by mouth** ***or*** ☐ **4 puffs by mouth**
8) A student must be transported by medical personnel or a parent/guardian, and may NOT remain at school.

☐ Yes ☐ No Can this student responsibly **carry** the emergency medication in their backpack/purse?
☐ Yes ☐ No Can this student responsibly **self-administer** the emergency medication?
☐ Yes ☐ No Student demonstrated for the LHCP the skill necessary to self-administer the epinephrine?

Healthcare Provider's Signature:_____ Date: _____

Healthcare Provider's Name:_____ Phone: _____ Fax: _____

SIGNS OF ALLERGIC REACTION

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth	LUNG	Shortness of breath, repetitive coughing, and/or wheezing
SKIN	Hives, itchy rash, and/or swelling about the face or extremities	HEART	Fainting, dizziness, weak pulse, blueness, and/or pale skin
THROAT	Sense of tightness, itching in the throat, hoarseness, change in voice, throat clearing	GENERAL	Panic/anxiety, sudden fatigue, chills, fear of impending doom, confusion, feeling like something bad is about to happen
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea	OTHER	Some students may experience symptoms other than those listed

INDIVIDUAL CONSIDERATIONS

This section to be completed by parent/guardian

K-5 SCHOOLS – For Food Allergy only

NOTE: **Meals and food from home provide the safest food option at school.**

☐ Foods approved by parent

☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.

☐ Parent/guardian should be advised of any planned parties as early as possible.

☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens.

Egg allergies: May student eat baked goods containing eggs? ☐ Yes ☐ No

Seating restrictions needed in cafeteria ☐ Yes ☐ No

Student should remain with teacher or parent/guardian during the entire field trip. ☐ Yes ☐ No

GRADE 6-12 SCHOOLS – No seating restrictions. Students make own food choices.

☐ Yes ☐ No – Middle/High school student may self-carry for field trip **(LHCP must sign off).**

*** The transportation department will be alerted to the student's allergy.***

Epinephrine Auto-Injector should be found in: ☐ **Health Room** ☐ **with Student**

EMERGENCY CONTACTS

Parent/Guardian	Phone	Relationship
1.		
2.		
Emergency Contact	**Phone**	**Relationship**
1.		

PARENT/GUARDIAN CONSENT – You must complete and SIGN

☐ I consent to the evaluation and accommodation plan here provided, and have received a copy of Section 504 Parent/Student Rights.

☐ I request that authorized school personnel assist my child to take the medicine(s) described above. (if no box is checked, this option is the default.)

☐ I request that my child be permitted to self-administer the medicine(s) described above. I will hold harmless and indemnify the District, its officers, employees and personnel against all claims of liability arising out of the student's self-administration or carrying of medication.

☐ **I am a student and at least 18 years old** and sign this form on my own behalf (RCW 26.28.015 or RCW 70.02.130).

My signature indicates my permission for the exchange of information between school staff and the health care provider, and my understanding that the District and school staff will not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and Washington law. I understand that if this is a plan for a life-threatening condition it can only be discontinued, in writing, by a healthcare provider.

The permission to possess and self-administer medication may be revoked by the school nurse if it is determined that your child is not safely and effectively possessing and self-administering medication.

It is strongly recommended that extra medication be provided and stored in the school heath room.

Parent Signature: **Date:** ☐ Parent/Guardian Signature on File

School Nurse – Complete this section.

-Student has demonstrated to the school nurse the skill necessary to use the medication and any device necessary to self-administer the medication. ☐ Yes ☐ No

School Nurse: **Date:**

A copy of this plan is available in Skyward and will be kept in the school health room and copies will be given to:

☐ Teachers and/or Specialists ☐ Transportation ☐ Coach ☐ Other: