

ANAPHYLAXIS CARE PLAN/MEDICATION ORDERS

504 Plan ☐

Plan ___ of ___

Place
student
picture
here

Allergy to: _____

STUDENT NAME

Birthdate

Grade School ☐ Bus # ☐ Walk ☐ Drive

Allergy History ☐ History of anaphylaxis Date of Last Reaction Weight

Other Allergies: ☐ Student has Asthma (increased risk factor for severe reaction)

Brief Medical History (including current medications)

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 **OTHER:**

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

If student has symptoms or you suspect 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®) ☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)
☐ Levalbuterol 2 puffs (Xopenex®) ☐ 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 has demonstrated EAI use in LHP's office
☐ Student may self-administer EAI and/or antihistamine ☐ Student has demonstrated inhaler use LHP's office
☐ 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 *******

LHP Signature

LHP Print Name

Start date

End date ☐ Last day of school ☐ Other

Date

Telephone

Fax

Anaphylaxis Care Plan / 504 Plan – Page 2 – for Parent/Guardian to complete

STUDENT NAME _____

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 which could include a designated allergy table in the cafeteria
☐ 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

EMERGENCY CONTACTS

Parent/Guardian	Name	Parent/Guardian	Name		
	Primary #		Primary #		
	Other #		Other #		
	Other #		Other #		
Name:		Relationship:		Phone:	
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

504 Plan ☐

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.

Liberty School District
Allergy Assessment Form for Parent to Complete and Sign

Student Name: _____ Grade: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider treating allergy: _____ Phone: _____

Did your child's **health care provider** tell you the allergy may be **life-threatening**?....☐ No ☐ Yes
(If YES, please make an appointment with the school nurse prior to starting school)

History and Current Status

Check the items that have caused an allergic reaction:

- | | | |
|---|---|--|
| ☐ Peanuts | ☐ Fish/shellfish | ☐ Eggs |
| ☐ Peanut or nut butter | ☐ Soy products | ☐ Milk |
| ☐ Peanut or nut oils | ☐ Tree nuts (walnuts, almonds, pecans, etc.) | ☐ Bees, other insects |

Please list any others: _____

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

When was the last allergic reaction? _____

Are the allergic reactions: ☐ staying the same ☐ getting worse ☐ getting better

Does your child have eczema or other skin related problems?☐ No ☐ Yes

Does your child have asthma?☐ No ☐ Yes

Does your child use medications for his/her asthma?☐ No ☐ Yes

What medications is he/she using for their asthma? _____

Triggers and Symptoms

What has to happen for your child to react to the problem allergen(s)? *(Check all that apply)*

- ☐ Eating foods ☐ Touching foods ☐ Smelling foods ☐ Bite/Sting ☐ Other, explain: _____

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

How quickly do the signs and symptoms appear after exposure to the allergen(s)?

_____ Seconds _____ Minutes _____ Hours _____ Days

Treatment

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction?

☐ No ☐ Yes, explain: _____

Does your child understand how to avoid items that cause allergic reactions?☐ Yes ☐ No

What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

Have you used the treatment? ☐ No ☐ Yes

Does your child know how to use the treatment? ☐ No ☐ Yes

➤ Please describe any side effects or problems your child had in using the suggested treatment:

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

☐ Yes.

☐ No, I need to get the form, have it completed by our **Physician** and return it to school.

☐ N/A, Allergy is to insect, animal, or other.

If medication is to be available at school, have you filled out an Individual/Emergency/Medication Order/504 Care Plan for school?

☐ Yes.

☐ No, I need to get the form, have it completed by our health care provider and return it to school.

If medication is needed at school, have you brought the medication/ treatment supplies to school? ☐ Yes.

☐ No, I need to get the medication/treatment and bring it to school before the first day of attendance.

What do you want us to do at school to help your child avoid problem foods or allergens?

ADDITIONAL COMMENTS:

State law requires all students with life-threatening health conditions are to have medication or treatment orders, a nursing care plan, and staff training completed prior to attending school each year.

Parent/Guardian Signature _____ Date: _____

Reviewed by R.N. _____ Date: _____

NURSE REFERRAL FOR EMERGENCY CAREPLAN

☐ YES

☐ NO