

ALLERGY CARE PLAN AND MEDICATION ORDERS

No History of Anaphylaxis

Plan ____ of ____

Place
student
picture
here

STUDENT NAME

Birthdate

Grade

School

☐ Bus #

☐ Walk

☐ Drive

Other Allergies

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

Date of last reaction, symptoms experienced

Brief medical history

Antihistamine location ☐ Office ☐ Backpack ☐ On person ☐ Other _____

Inhaler(s) location ☐ Office ☐ Backpack ☐ On person ☐ Other _____

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

If student has symptoms or you suspect exposure to: _____:

1. Administer: _____ (antihistamine) _____ (mg)

☐ May repeat antihistamine dose after _____ minutes

Antihistamine side effects: ☐ Drowsiness ☐ Hyperactivity ☐ Other: _____

2. If student has asthma and is coughing, wheezing, short of breath, and/or has chest tightness, administer:

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Other _____

☐ May repeat every _____ minutes as needed for symptoms

3. Call school nurse at ext. 1228 and parent/guardian at number listed on page 2

4. Student may carry and is trained to self-administer antihistamine. ☐ Yes ☐ No

5. Student may carry and is trained to self-administer rescue inhaler. ☐ Yes ☐ No

SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY **Some Symptoms can be life-threatening—ACT FAST** **IF SYMPTOMS INCREASE – DON'T HESITATE TO CALL 911**

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 call 911.

USUAL SYMPTOMS of an anaphylactic reaction:

MOUTH—Itching, tingling, or swelling of the lips, tongue, or mouth

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

GENERAL—Panic, sudden fatigue, chills, fear of impending doom

HEART—"Thready" pulse, "passing out", fainting, blueness, pale

LUNG—Shortness of breath, repetitive coughing, and/or wheezing

GUT—Nausea, stomach ache/abdominal cramps, vomiting, diarrhea

THROAT—Sense of tightness in the throat, hoarseness, hacking cough

1. CALL 911 – if symptoms increase

2. Advise EMS that antihistamine has been administered and no epinephrine is available

3. Notify school nurse and parent/guardian of change in condition

******* 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:

Allergy Care Plan – Page 2 – for Parent/Guardian to Complete**Food Allergy Accommodations: (check applicable)**

- ☐ 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 Accommodations: (check applicable) Transportation staff should be alerted to student's allergy

- Student carries allergy medication on the bus ☐ Yes ☐ No
- Medication can be found in ☐ Backpack ☐ On person ☐ Other (specify) _____
- Student will sit at front of the bus ☐ Yes ☐ No
- Other (specify) _____

Field Trip/Extracurricular Activity Accommodations: (check applicable)**Allergy medication must accompany student during any off-campus activity**

- 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, Specify: _____

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 allergy medication ☐ Yes ☐ No Provide extra for office ☐			
My child may carry and is trained to self-administer their rescue inhaler ☐ Yes ☐ No Provide extra for office ☐			

- 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 care plan includes a medication order, which should be discontinued by the LHP if or when appropriate.
 - I authorize the exchange of information about my child's 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 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 allergy 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 has 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	

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