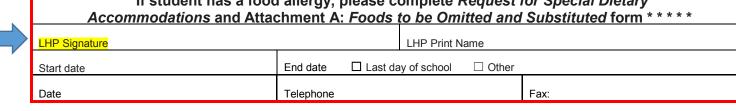
ALLERGY CARE PLAN AND MEDICATION ORDERS No History of Anaphylaxis date STUDENT NAME **Birthdate** Grade School ☐ Bus # ■ Walk ☐ Drive Other Allergies Student has Asthma (increased risk factor for severe reaction) Date of last reaction, symptoms experienced **Brief medical history Antihistamine location** 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 (is stung, eats food he/she is allergic to, or exposed to allergen): 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 and parent/guardian. ASchell, RN 509-660-0400 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 CALL 911 – if symptoms increase 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



Allergy Care	Plan – Part 2 – Pare	nt/Guardian (S	STUDENT):	
Food Allergy Accommodations				
☐ Foods and alternative snacks will be a			an	
☐ Notify parent/guardian of any planned				
☐ Classroom projects should be reviewe		o avoid specified	d allergens	
Student is able to make their own food de		□ No		
When eating, student requires:   Specifi	=			
☐ No res	trictions UOther			
Transportation: Transportation staff sh				
<ul> <li>Student carries allergy medication on the bus ☐ Yes ☐ No</li> <li>Medication can be found in ☐ Backpack ☐ On person ☐ Other (specify)</li></ul>				
			er (specify)	<del></del>
<ul><li>Student will sit at front of the bus</li><li>Other (specify)</li></ul>	☐ Yes	□ No		
Field Trip/Extracurricular Activity: A/	lleray medication must	t accompany st	tudent during any off-	campus activity
Student must remain with the teacher				No
Field trip staff must be trained to me		· ·	•	
Other accommodations		pian (noam oa	io piani maot aloo aloos	
Does student need other classroom,	school activity, or reces	ss accommodati	ons 🗆 Yes 🗆	No
If yes, contact the school counselor	or 504 coordinator			
EMERGENCY CONTACTS				
Name	Parent/Guardia	Name		
Primary # Other # Other #		Primary #		
Other #		Other#		
Other #	lian	Other #		
Name:	Relationship:		Phone:	
My child may carry and is trained to self-admi	inister their allergy medication	☐ Yes ☐ No	Provide extra for office	
My child may carry and is trained to self-adm	inister their rescue inhaler	☐ Yes ☐ No	Provide extra for office	
<ul> <li>A new care plan and medication/treatment of the care plan,</li> <li>If any changes are needed to the care plan,</li> <li>It is the parent/guardian's responsibility to all the plant of the pla</li></ul>	it is the parent/guardian's respect all other <b>non-school</b> progr	consibility to contact rams of their child's	health condition.	
<ul> <li>Medical information may be shared with sch</li> <li>I have reviewed the information on this care</li> </ul>	plan/504 and medication/trea	tment order and req	uest/authorize trained school	employees to provide
<ul> <li>this care and administer medication/treatme</li> <li>This care plan includes a medication order,</li> </ul>				
I authorize the exchange of information about				
I have reviewed and agree with this hea	Ith care plan/504 and me	dication/treatme	nt order.	
Parent/Guardian Signature		_	eate	
I have demonstrated the correct use of the a	entihistamine/inhaler to the r			
I agree never to share my medication with an				
I agree that if I self-administer medication, I	will report to an adult at scho	ool if the nurse is no	ot available or present.	
Student Signature		Date		

## 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: $\Box$ Yes $\Box$ No $\Box$ 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: $\square$ Yes $\square$ No Device(s) if any, Used Expiration date(s) Registered Nurse Signature Date