

Salado ISD Health Services Emergency Plan for Severe Allergy

Guidance for Non-licensed School Personnel

Year: _____ Campus: _____

Place student pic

Student	DOB	SISD ID #	Grade/HR
Allergic to:		Extremely allergic to following food:	
Has Asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>* higher risk for allergic reaction</i>		Therefore:	
Permitted to carry & self-administer: <input type="checkbox"/> Inhaler <input type="checkbox"/> EpiPen (school nurse to complete back if yes)		<input type="checkbox"/> Give Epinephrine immediately for ANY symptoms if the allergy was likely eaten	
Has student had a reaction that required the use of an EPIPEN? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Give Epinephrine immediately if the allergen was DEFINETLY EATEN, even if no symptoms noted	
Special Diet modification needed: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)		Does student understand how to avoid food/allergen? <input type="checkbox"/> No <input type="checkbox"/> Yes Does student know when & how to tell an adult they may be having an allergy related problem? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Medication at school: N/A In Health Office Student carries in: _____ Other: _____

ACTIONS TO TAKE FOR MINOR SYMPTOMS

<p>IF YOU SEE ANY OF THIS: MOUTH: itchy mouth SKIN: few hives around mouth/face, mild itch GUT: mild nausea/discomfort</p> <p>The severity of the symptoms can quickly change</p>	<p>DO THIS: <input type="checkbox"/> Give antihistamine** _____ (name/dose)</p> <ol style="list-style-type: none"> Stay with student, notify school nurse/principal and parent that a suspected allergic reaction has occurred If symptoms progress (see below), use EPINEPHRINE <p>**IMPORTANT: asthma inhalers and antihistamines cannot be depended on to replace epinephrine in anaphylaxis</p>
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ACTIONS TO TAKE FOR MAJOR SYMPTOMS

<p>IF YOU SEE ANY OF THIS: <u>One or more of the following potentially life-threatening symptoms:</u></p> <p>LUNG: Short of breath, wheeze, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy, confused THROAT: tight, hoarse, trouble breathing/swallowing MOUTH: obstructive swelling (tongue and/or lips) SKIN: many hives over body</p> <p><u>Or combination of symptoms from different body areas:</u> SKIN: hives, itchy rashes, swelling (eyes, lips, etc.) GUT: vomiting, diarrhea, crampy pain</p>	<p>DO THIS: <input type="checkbox"/> INJECT IMMEDIATELY EPINEPHRINE _____ (DOSE)</p> <ol style="list-style-type: none"> Call 911. Inform operator that EPINEPHRINE was given. Stay with student, notify school nurse/principal and parent that a suspected allergic reaction has occurred Give additional medications: <p><input type="checkbox"/> Give antihistamine** _____ (name and dose)</p> <p><input type="checkbox"/> If asthmatic, give inhaler/bronchodilator**:</p> <p>Other instructions: _____</p> <p>MONITORING: Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.</p>
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Other instructions/Plans to avoid allergen: _____

PHYSICIAN/PARENTAL AUTHORIZATION FOR EMERGENCY PLAN FOR SEVERE ALLERGIC REACTION

Physician authorization: Print Name		Physician Signature		Physician Phone		Date	
Parental Authorization: Signature		Best emergency phone		Other phone		Date	
Emergency Contact				Phone		Other phone	

School Use Only

Plan Developed by(nurse):	Date	Caregiver Trained	Date
Caregiver Trained	Date	Caregiver Trained	Date

Salado ISD Health Services
Emergency Plan for Severe Allergy

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Year: _____ Campus: _____

Place student pic

Student Name	DOB	SISD #	Grade/Homeroom	Bus #
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Severe Allergy: Care Plan Review

Printed Name	Signature	Position/Relationship	Date	InstructorInitials

The following is to be completed by the school nurse if student will carry and self-administer an EPIPEN and/or asthma inhaler.

EPIPEN

OBSERVED

Yes No

- Health care action plan complete
- Demonstrated correct use/administration of Epipen
- Recognizes early signs and symptoms of an allergic reaction
- Agrees to come directly to the Nurse's Office if early signs & symptoms occur
- Agrees not to share medication with others
- Agrees to keep medication in: _____(location)
- Carries medication self-administration pass with medication
- Keeps a second Epipen in the Nurse's Office
- The student has demonstrated the purpose, appropriate method and frequency of his/her Epipen. I feel he/she shows sufficient responsibility to carry the Epipen on his/her person in school.**

Nurse Signature	Date
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ASTHMA INHALER

OBSERVED

Yes No

- Health care action plan complete
- Demonstrated correct use/administration of asthma inhaler
- Recognizes proper and prescribed timing for medication
- Agrees not to share medication with others
- Agrees to keep medication in : _____(location)
- Agrees to come directly to the Nurse's Office if asthma symptoms persist
- Carries medication self-administration pass with medication
- Keeps a second label container in the Nurse's Office
- The student has demonstrated the purpose, appropriate method and frequency of his/her meter dose inhaler. I feel he/she shows sufficient responsibility to carry the inhaler on his/her person in school.**

Nurse Signature	Date
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