717 JORDAN PUBLIC SCHOOLS
500 Sunset Drive
Jordan, Minnesota 55352
952-492-6200 main | 952-492-4445 fax

DISTRICT NURSE
jordannurse@isd717.org

SEVERE ALLERGY/ANAPHYLAXIS EMERGENCY CARE PLAN

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has the following allergy:

_____ Peanuts
_____ Tree Nuts
_____ Bee Stings
_____ Insects
_____ Other (please list):_____

Please fill out the **Allergy Questionnaire** to help understand the nature of your child's allergy and to help better care for your child while he/she is in school. Your child's physician must fill out and sign the **Severe Allergy/Anaphylaxis Emergency Care Plan**. Please return the Allergy Questionnaire and the Severe Allergy/Anaphylaxis Emergency Care Plan before the start of school.

All medication brought to school must be in its **original packaging, unexpired and with its original label** from the pharmacy. Any medication that is expired or without a label will be sent home.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School**	Address: 815 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4446
_____ **Jordan Middle School**	Address: 500 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4450
_____ **Jordan High School**	Address: 600 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4425

Thank you and please call or email us if you have any questions or concerns.

Darci Griffiths MSN, RN, LSN
District Nurse - JHS
952-492-4410
jordannurse@isd717.org
Fax: 952-492-4425

Jenn Passe, RMA
Jordan Middle School
952-492-4232
Fax: 952-492-4450

Jenna Hentges, RN
Jordan Elementary School
952-492-4278
Fax: 952-492-4446

Severe Allergy/Anaphylaxis Emergency Care Plan - Independent School District 717

Student Name: _____ DOB: _____Grade: _____

Child has an allergy to _____

Severe Allergy and Anaphylaxis	
ANY of these symptoms, **give Epinephrine** - Shortness of breath, wheezing or coughing - Weak pulse - Fainting or dizziness - Tight or hoarse throat - Trouble breathing or swallowing - Swelling of lips or tongue - Severe vomiting or diarrhea - Many hives or redness over body - Feeling of "doom" or confusion - Altered consciousness or agitation ❑ **Special situation:** If this box is checked, the child has an extremely severe allergy. Even if child has MILD symptoms, **give Epinephrine**	1. Inject Epinephrine **ASAP** and note what time it was given 2. Call **911** 3. Stay with the child and call parents 4. Give a second dose of Epinephrine, if symptoms worsen or do not improve in 5 minutes and note the time 5. Give other medications, if prescribed. Do not use other medicine in place of Epinephrine

Mild Allergic Reaction	
Any **one** mild symptoms, **monitor child** - Itchy nose, sneezing, itchy mouth - A few hives - Mild nausea or stomach discomfort	1. Stay with child and monitor closely 2. Give antihistamine (if ordered) 3. Call parents 4. If more than 1 symptom or severe symptoms develop, **give Epinephrine** (see above)

Epinephrine Order

Medication: _____ Dose: _____ Intramuscularly

Student was trained to self-administer and may self-carry epinephrine: ❑ Yes ❑ No

Antihistamine Order

Medication Name: _____ Dose: _____ Route: _____ Frequency _____

Other:_____

Physician Signature_____Date_____

Physician Name_____ Phone:_____Fax_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Allergy Questionnaire - Independent School District 717

Student Name: _____ DOB: _____
Grade: _____ Teacher: _____

Allergy History

1. Please list all allergens:_____
2. When was your child diagnosed with anaphylaxis? _____
3. How often has your child been treated for a minor reaction?_____
4. How often has your child been treated for a major reaction?_____
5. Please describe the specific symptoms your child experiences during an allergic reaction:
   _____
6. Does your child recognize the symptoms of an allergic reaction? ❑ Yes ❑ No
7. Does your child have asthma? ❑ Yes ❑ No
8. What medications will your child have at school for allergies?
   ❑ Epinephrine ❑ Antihistamine (Benadryl) ❑
   Other_____
   Emergency medication location(s): ❑ Nurse's office ❑ With Student ❑ With Teacher
   ❑ Kids Company ❑ Other_____
9. Is your child able to identify what allergen(s) cause an allergic reaction? ❑ Yes ❑ No
10. Please indicate below any modifications requested for your child while in school: (check all that apply):

PEANUT/TREE NUT ALLERGY	**BEE STING ALLERGY**
In the classroom: ❑ **ALL** snacks will be provided by parent ❑ Student will chose snacks from snack cart ❑ A letter will be sent to classmates' parents requesting they do not send birthday treats with known allergens ❑ A letter will be sent to classmates' parents asking they avoid sending foods with known allergens in *their child's* daily snacks ❑ Teacher will review lesson plans and projects and modify as needed to protect student ❑ NO ACCOMMODATIONS NEEDED **In the cafeteria:** ❑ Child will sit at the peanut-safe table ❑ NO ACCOMMODATIONS NEEDED **On the bus:** ❑ Child will sit in the first two rows ❑ Parent will introduce student to driver and show driver where EpiPen is located ❑ NO ACCOMMODATIONS NEEDED	**Recess:** ❑ EpiPen will be kept with recess staff during recess ❑ Child will be introduced to recess staff by nurse ❑ NO ACCOMMODATIONS NEEDED **Outdoor Phy-ed:** ❑ Student will be responsible for getting EpiPen from nurse's office before outdoor phy-ed ❑ Student needs a reminder to get EpiPen before outside phy-ed ❑ NO ACCOMMODATIONS NEEDED **Bag Lunch:** *(On "Bag Lunch" days students eat outside. Students with allergies to bee stings eat indoors, unless otherwise indicated below, due to the increased risk of bee exposure with the presence of food and drink)* ❑ Student will eat **indoors** on bag lunch days ❑ Student may eat **outdoors** on bag lunch days

A copy of this will be kept in the substitute folders and will be distributed to all staff involved with your child.

Parent Name _____(h) _____ (w) _____
Parent Signature_____Date_____
School Nurse_____Date_____