Bradley County schools | Individualized Health Plan | **Severe Allergy**

Student Name _____ Grade_____

Date of Birth ____/____/____ Teacher_____

To be completed by PARENT / GUARDIAN:

Student is SEVERELY Allergic to: _____

Usual reaction occurring with exposure to the above allergen is:_____

_____

Student routinely takes allergy medication at home? YES NO

If YES, what medication? _____

Does student have a prescription for EPIPEN? YES NO

If YES, has student ever been injected via EPIPEN for allergy reaction? YES NO

If FOOD ALLERGY, I request my student sit at SAFE ZONE table in cafeteria YES NO

Physician managing condition: Dr._____

Phone (____) ____-_____

Fax (____) ____- _____

Note: Parent must provide medication in original pharmacy-labeled container. Parent / Guardian is responsible for notifying school nurse for any change in student condition or change in treatment regimen. **Parent / Guardian signature serves as consent for information to be requested from or exchanged with the physician(s) listed above.**

Parent / Guardian signature: _____ Date ___/___/___

Phone:_____

SIGNS OF A SEVERE ALLERGIC REACTION include:

- Itching and swelling of the lips, tongue, face
- Tightness in throat or "itchy throat", hoarseness,
- Coughing, sensation of choking
- Hives, itching, or rash
- Abdominal pain, Nausea, Vomiting, Diarrhea
- Shortness of breath and possible wheezing
- Thready' pulse, possible fainting, dizziness

The symptoms can change quickly and progress from mild to severe or life-threatening. Do not hesitate to call 911 if you suspect a severe anaphylactic reaction.

PLAN: Avoid exposure to known allergen.
Administer medication(s) as ordered by Physician
If EPIPEN is administered, Call 911.

FOR SCHOOL NURSE USE ONLY:

Plan rev'd by _____ Date___/___/___

MD Orders Req'd:___/___/___ Rec'd___/___/___

_____Added to DD

_____Medical Alert to Grade level teachers,Cafeteria Mgr., PE Teacher, and specialty teachers

Medication Location :_____

TO BE COMPLETED BY PHYSICIAN:
(or attach copy of Physician Orders)

Diagnosis:_____

Medication to be administered while at school and instructions for calling 911:

_____

_____

_____

_____

_____

_____

_____

MD Signature_____

Date ____/____/____

TN Department of Education

Allergy and Anaphylaxis Emergency Plan

Date of Plan: _____

Student's Name: _____ Date of Birth: _____ Age: ____ Weight: _____ pounds (____ kg)
Student's School System: _____ Student's School: _____
Student has allergy to _____
Student has asthma ☐ Yes (If yes, higher risk for severe reaction) ☐ No
Student has had anaphylaxis ☐ Yes ☐ No
Student has received instruction and has permission to self-carry epinephrine and use independently ☐ Yes ☐ No

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, use epinephrine.

For **ANY** of the following **SEVERE SYMPTOMS OR A COMBINATION** of symptoms from different body areas


Shortness of breath, wheezing, or coughing


Pale or bluish skin, weak pulse, fainting or dizziness


Tight or hoarse throat, trouble breathing or swallowing


Swelling of lips or tongue that bothers breathing


Many hives or redness over body


Feeling of "doom," confusion, altered consciousness or agitation


Repetitive vomiting or severe diarrhea

☐ **SPECIAL SITUATION:** If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

↓

1. Inject epinephrine right away!
Note time when epinephrine was given.

2. Call 911.
- Ask for ambulance with epinephrine.
- Tell rescue squad when epinephrine was given.

3. Stay with Student and:
- Call parents and student's healthcare provider.
- If symptoms get worse or continue after 5 minutes, give a second dose of epinephrine.
- Keep student lying on back. If the student vomits or has trouble breathing, keep child lying on his or her side.

4. Give other medicine (if applicable) following epinephrine
- Antihistamine
- Inhaler/bronchodilator if wheezing

MILD SYMPTOMS


Itchy or runny nose, sneezing


Itchy mouth


Mild nausea or discomfort


A few hives, mild itchy skin

MONITOR STUDENT

- Stay with student and watch him or her closely.
- Give antihistamine (if listed below).
- Call parents.

If more than 1 symptom or severe allergy anaphylaxis symptoms develop, use epinephrine.

MEDICATION/DOSES

Epinephrine, intramuscular (list type):
_____

Epinephrine Dose:
☐ 0.1 mg
☐ 0.15 mg
☐ 0.3 mg

Antihistamine, by mouth (list type): _____
Antihistamine Dose: _____
Other (e.g., inhaler/bronchodilator if child has asthma):
_____

EMERGENCY CONTACTS

Healthcare Provider: _____
Phone: _____
Parent/Guardian: _____
Phone: _____
Other Emergency Contact Name/Relationship:
_____
Phone: _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature | Date | Physician/HCP Authorization Signature | Date

Bradley County Schools

Dr. Linda Cash
Director of Schools

Date:_____

Dear Parent/Guardian of:_____

You have indicated a (an)_____allergy for your student.

Bradley County Schools has updated the procedures for Life Threatening Allergies in a continuing approach to keep your child with allergies safe while at school. As always, we take life-threatening food allergies very seriously and have implemented the following procedures.

- Students with Life-Threatening Allergies must have medical documentation to support the allergy. Attach the documentation to the Student Health Form.
- Students with documented life-threatening allergies are not to consume the food allergen while at school. If you have listed a food that is simply an intolerance and not a life-threatening allergen, a notation should be made on the attached Student Health Form.
- Bus drivers must be notified of your child's life-threatening allergies if your child is a bus-rider. You should speak with your child's bus driver about allergies and remind your student not to consume these foods on the bus.

Please sign the appropriate response:

[] Yes, I have informed my child's bus driver.

_____ Date _____

[] No, I have not informed my child's bus driver.

_____ Date_____

[] Not applicable. My child does not ride a school bus.

_____ Date_____

- Parents are encouraged to provide an identification bracelet for the students.
- Students with life-threatening allergies will be provided an allergen-friendly table in the cafeteria. The student may have a "buddy" eat with them.

Please sign the appropriate response:

[] Yes, I would like my child to eat at an allergen-friendly table.

_____ Date_____

[] No, I would not like my child to eat at an allergen-friendly table, and I understand the risks of this decision.

_____ Date_____

- Children are encouraged to practice hand-washing and to practice self-advocacy. We want your child to be informed about his/her allergy, the dangers of exposure, and what to do if he/she believes a reaction is occurring.

Complete this form along with the attached Student Health Form and return to your child's school. If you have any questions or concerns, please contact your school principal or school nurse.

Dr. Linda Cash, Director of Schools

800 South Lee Hwy.
Cleveland, TN 37311
(423) 476-0620
Fax (423) 476-0485

Known Severe Allergy to Insect Bites / Stings

Individual Student Health Plan for _____

Teacher: _____
Grade: _____
Year: _____-_____

Student has known allergy to: _____

What happens when your child is stung? _____
_____

PLAN:

For Stinger left in skin.....	Remove with fingernail or tweezers Do not push, pinch, or squeeze stinger
For Redness or swelling at site...	Administer Medication: _____ Dose: _____ Apply ice Keep site below level of the heart May apply OTC anti-itch product for comfort
For throat tightening, cough, shortness of breath, +/or wheezing, fainting, low BP, thready pulse, etc...	Administer Medication: _____ Dose: _____ Keep in semi-upright position Call 911 Call Parent DO NOT LEAVE STUDENT ALONE and provide necessary support measures (CPR, etc) until EMS arrives!

Epipen, if required, is prescribed by Dr. _____
Phone _____ Fax _____

Note: School Staff is trained in use of EPIPEN in the absence of a nurse. A copy of this plan is provided for teacher reference and kept on file in the office.

For Office Use only:

Plan reviewed by: _____ Date ___/___/___
Location of EPIPEN_____ Exp date___/___/___