

Place  
student  
picture  
here**ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS/504****ALLERGY TO:** \_\_\_\_\_**Plan:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date plan created:** \_\_\_\_ **Date plan revised:** \_\_\_\_ **Weight:** \_\_\_\_ **Height:** \_\_\_\_**NAME:** \_\_\_\_\_ **Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **PE/Sport:** \_\_\_\_\_**Grade:** \_\_\_\_ **School:** \_\_\_\_\_ ☐ **Bus #** \_\_\_\_ ☐ **Walk** ☐ **Drive****Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Preferred Hospital:** \_\_\_\_\_**History (including current medication):** \_\_\_\_\_**Allergy History:** ☐ **History of anaphylaxis/severe reaction** ☐ **Skin testing indicates allergy** **Date of Last Reaction:** \_\_\_\_\_**Epinephrine location** ☐ Backpack ☐ On person ☐ Other: Health Room**Inhaler(s) location** ☐ Backpack ☐ On person ☐ Other: Health Room**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 give Epinephrine and call 911.****USUAL SYMPTOMS of an allergic reaction: (please check those that are known/history for student)****MOUTH (Lips, Tongue):** ☐ Itching ☐ Tingling ☐ Swelling **THROAT:** ☐ Sense of tightness ☐ Hoarseness ☐ Hacking cough**GUT:** ☐ Nausea ☐ Stomach ache/cramps ☐ Vomiting ☐ Diarrhea **LUNG:** ☐ Shortness of breath ☐ Repetitive coughing ☐ Wheezing**SKIN:** ☐ Hive ☐ Itchy Rash ☐ Swelling of the face/extremities **HEART:** ☐ Thready pulse ☐ Passing out/Fainting ☐ Blueness ☐ Pale**GENERAL:** ☐ Panic ☐ Sudden Fatigue ☐ Chills ☐ Fear ☐ Impending doom***This Section to be Completed by a Licensed Healthcare Provider (LHP)***If student has symptoms or you suspect probable exposure (is stung, eats food he/she is allergic to, or exposed to allergen)  
Administer1. ☐ Epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg (Jr)  
☐ May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved **OR** symptoms return and EMS has not arrived☐ Neffy Intranasal Epinephrine ☐ 2 mg ☐ 1 mg  
☐ May repeat Neffy (if available) in 5 minutes in same nostril if symptoms are not relieved **OR** symptoms return and EMS has not arrived

2. Call 911 – Advise EMS that Epinephrine has been administered

3. Stay with student

4. After Epinephrine administered, administer \_\_\_\_\_ (antihistamine) \_\_\_\_\_ (mg)

5. If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after Epinephrine, administer

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)☐ Levalbuterol 2 puffs (Xopenex®) ☐ Other \_\_\_\_\_☐ May repeat every \_\_\_\_\_ minutes as needed for symptoms

6. Notify school nurse and parent/guardian

7. A Student given Epinephrine must be monitored by medical personnel or a parent and may NOT remain at school

☐ Student may carry Epinephrine and/or antihistamine ☐ Student has demonstrated Epinephrine use in LHP's office☐ Student may self-administer Epinephrine and/or antihistamine ☐ Student has demonstrated inhaler use LHP's office☐ Student may carry and self-administer Inhaler**SIDE EFFECTS of medication(s):**Epinephrine : **increased heart rate,** \_\_\_\_\_ **Antihistamine: sleepy** \_\_\_\_\_Albuterol/Levalbuterol: **increased heart rate, shakiness,** \_\_\_\_\_\*\*\*\*\* If student has a food allergy, please complete *Request for Special Dietary Accommodations* \*\*\*\*\*

|               |           |                                             |                                |
|---------------|-----------|---------------------------------------------|--------------------------------|
| LHP Signature |           | LHP Print Name                              |                                |
| Start date    | End date  | <input type="checkbox"/> Last day of school | <input type="checkbox"/> Other |
| Date          | Telephone | Fax                                         |                                |

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.

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**Anaphylaxis Care Plan – Part 2 – Parent/Guardian (STUDENT):** \_\_\_\_\_

**Food Allergy Accommodations**

- ☐ 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 staff should be alerted to student's allergy**

- Student carries Epinephrine on the bus/transportation ☐ Yes ☐ No
- Epinephrine can be found ☐ On person ☐ Other (specify) \_\_\_\_\_
- Student will sit at front of the bus ☐ Yes ☐ No

**Field Trip/Extracurricular Activity: Epinephrine *must accompany student during any off campus activity***

- The 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:** \_\_\_\_\_

**EMERGENCY CONTACTS**

|                                                                           |           |                                                          |                                                                                   |
|---------------------------------------------------------------------------|-----------|----------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>Parent/Guardian</b>                                                    | Name      | <b>Parent/Guardian</b>                                   | Name                                                                              |
|                                                                           | Primary # |                                                          | Primary #                                                                         |
|                                                                           | Other #   |                                                          | Other #                                                                           |
|                                                                           | Other #   |                                                          | Other #                                                                           |
| Name:                                                                     |           | Relationship:                                            | Phone:                                                                            |
| Name:                                                                     |           | Relationship:                                            | Phone:                                                                            |
| My child may carry and is trained to self-administer their Epinephrine    |           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Provide extra for office <input type="checkbox"/> Yes <input type="checkbox"/> No |
| My child may carry and is trained to self-administer their rescue inhaler |           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Provide extra for office <input type="checkbox"/> Yes <input type="checkbox"/> No |
| My child may carry their Epinephrine (needs assistance to administer)     |           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                   |

- A new individual health plan (IHP) and medication/treatment orders must be submitted each school year.
- If any changes are needed on the IHP, 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 staff, if they are called.
- I have reviewed the information on this IHP/504 and medication/treatment orders and request/authorize trained school employees to provide this care and administer medication/treatments in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- This is a life-threatening plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's IHP between the LHP office and the school nurse.
- I consent to the evaluation and annual re-evaluation of my child under 504 law regarding their IHP
  - If additional accommodations are needed please reach out to the school nurse to communicate a change to the IHP. These accommodations will be reviewed by your child's team and provided to staff as needed.
- *My signature below shows I have reviewed and agree with this health care/504 plan and medication/treatment orders.*

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

- I have demonstrated the correct use of the epi pen/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**

A Registered Nurse has completed a nursing assessment and developed this Anaphylaxis 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 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:

\_\_\_\_\_  
 Phone: