

ANAPHYLAXIS HEALTH PLAN & MEDICATION ORDERS

Click to
place
student
picture
here

ALLERGY TO: _____

NAME:	Birthdate:	Plan:	/
School:	School Year:	Grade:	
☐ Bus #	☐ Walk	☐ Drive	☐ Sport/Activity/PE
Provider:	Phone:	Preferred Hospital:	Height:
☐ Student Has Asthma	Date of Last Allergic Reaction:		Weight:
Allergy History: ☐ History of anaphylaxis/severe reaction ☐ Skin Testing Indicates Allergy			
History (including current medication): _____			

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 the 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	

Epinephrine Location: ☐ Backpack ☐ On Person ☐ Health Room ☐ Other:

Inhaler(s) Location: ☐ Backpack ☐ On Person ☐ Health Room ☐ Other:

****This section is to be completed by a Licensed Healthcare Provider (LHP)****

If a student shows symptoms or is exposed, or you suspect exposure, to a known allergen (Is stung, eats a known allergen, or is exposed to a known allergen), act immediately and follow these steps:

- ☐ Epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg
☐ 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
☐ Repeat neffy (if available) in 5 minutes **in the same nostril** if symptoms do not improve **OR** return, and EMS has not arrived
- Call 911 – Advise EMS that epinephrine has been administered
- Stay with student
- After epinephrine administered, administer _____ (antihistamine) _____ (mg)
- If student has 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 asthma medication every _____ minutes, as needed for symptoms up to _____ doses
- Notify school nurse and parent/guardian
- A Student given epinephrine must be monitored by medical personnel or a parent/guardian 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 ****Demonstration sign off by LHP is required for self-carry****

SIDE EFFECTS of medication(s): Epinephrine: **increased heart rate**

Antihistamine: **sleepiness**

Albuterol/Levalbuterol: **increased heart rate, shakiness**

**** If student has a food allergy, complete the Request for Special Dietary Accommodations****

LHP Signature: _____ LHP Print: _____

Start Date: _____ End Date: _____ ☐ Last Day of School Other: _____

Date: _____ Telephone: _____ Fax: _____

Anaphylaxis Health Plan - Parent/Guardian Section

STUDENT NAME: _____

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 location: ☐ Backpack ☐ On person ☐ Health Room ☐ Other: _____
- Inhaler(s) location: ☐ Backpack ☐ On person ☐ Health Room ☐ Other: _____
- Student will sit at front of the bus: ☐ Yes ☐ No

Field Trip/Extracurricular Activity: Epinephrine and health plan 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 plan

Other Accommodations: _____

EMERGENCY CONTACTS

Parent/Guardian	Name	Parent/Guardian	Name		
	Primary #		Primary #		
	Other #		Other #		
Name:		Relationship:		Phone:	
My child may carry and is trained to self-administer their epinephrine		☐ Yes ☐ No	Provide extra for office		☐ Yes ☐ No
My child may carry and is trained to self-administer their rescue inhaler		☐ Yes ☐ No	Provide extra for office		☐ Yes ☐ No
My child may carry their epinephrine (needs assistance to administer)		☐ Yes ☐ No			

- A new Anaphylaxis Health Plan and medication/treatment orders must be submitted each school year.
- If any changes are needed on the Health Plan, 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.
- I understand that the school district cannot be held responsible for negative outcomes resulting from my child self-administering their medication at my request.
- 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 Health Plan 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 Health Plan and medication/treatment order that can only be discontinued by the LHP.
- I authorize the exchange of information about my child's Health Plan between the LHP office and the school nurse.

For 504 Plans:

- I consent to the evaluation and annual re-evaluation of my child under 504 laws regarding their Health/504 Plan.
 - If additional accommodations are needed, I will contact the school nurse to communicate the needed change to the Health/504 Plan.
 - I understand that these accommodations will be reviewed by my child's team and provided to staff as needed.
- My signature below shows I have reviewed and agree with this Health /504 Plan and medication/treatment orders.

Parent/Guardian Signature: _____ **Date:** _____

- I have demonstrated the correct use of the epinephrine/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		☐ 504 Plan
A Registered Nurse has completed a nursing assessment and developed this Anaphylaxis Health Plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication(s) 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: _____

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