

ALLERGY CARE PLAN AND MEDICATION ORDERS**No History of Anaphylaxis**

Plan ____ of ____

STUDENT NAME		Birthdate	
Grade	School	☐ Bus #	☐ Walk ☐ Drive
Other Allergies		☐ Student has Asthma (increased risk factor for severe reaction)	

Date of last reaction, symptoms**Brief medical history**

Antihistamine location	☐ Office ☐ Backpack ☐ On person ☐ Other _____
Inhaler(s) location	☐ Office ☐ Backpack ☐ On person ☐ Other _____

This Section to be Completed by a Licensed Healthcare Provider (LHP)

If student has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to allergen):

- Administer: _____ (antihistamine) _____ (ml, mg, cc)
☐ May repeat antihistamine dose after _____ minutes
Antihistamine side effects: ☐ Drowsiness ☐ Hyperactivity
- If student has asthma and is coughing, wheezing, short of breath, and/or has chest tightness, administer:
☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Other _____
- Call school nurse and parent/guardian

SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY
Some Symptoms can be life-threatening—ACT FAST
IF SYMPTOMS INCREASE – DON'T HESITATE TO CALL 911

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 call 911.**

USUAL SYMPTOMS of an anaphylactic reaction:

MOUTH—Itching, tingling, or swelling of the lips, tongue, or mouth

SKIN—Hives, itchy rash, and/or swelling about the face or extremities

GENERAL—Panic, sudden fatigue, chills, fear of impending doom

HEART—"Thready" pulse, "passing out", fainting, blueness, pale

LUNG—Shortness of breath, repetitive coughing, and/or wheezing

GUT—Nausea, stomach ache/abdominal cramps, vomiting and/or

THROAT—Sense of tightness in the throat, hoarseness, hacking cough

diarrhea

- CALL 911** – if symptoms increase
- Advise EMS that antihistamine has been administered and no epinephrine is available
- Notify school nurse and parent/guardian of change in condition
- Student may carry and is trained to self-administer antihistamine ☐ Yes ☐ No
Student may carry and is trained to self-administer rescue inhaler ☐ Yes ☐ No

******* If student has a food allergy, please complete Request for Special Dietary Accommodations and Attachment A: Foods to be Omitted and Substituted form *******

LHP Signature		LHP Print Name	
Start date	End date ☐ Last day of school ☐ Other		
Date	Telephone	Fax:	

Allergy Care Plan – Part 2 – Parent/Guardian

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: Transportation staff should be alerted to student's allergy

- Student carries allergy medication on the bus ☐ Yes ☐ No
- Medication can be found in ☐ Backpack ☐ On person ☐ Other (specify)
- Student will sit at front of the bus ☐ Yes ☐ No
- Other (specify)

Field Trip/Extracurricular Activity: Allergy medication must accompany student during any off-campus activity

- 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

- Does student need other classroom, school activity, or recess accommodations ☐ Yes ☐ No

If yes, contact the school counselor or 504 coordinator

EMERGENCY CONTACTS

Parent/ Guardian	Name	Parent/ Guardian	Name		
	Primary #		Primary #		
	Other #		Other #		
	Other #		Other #		
Emergency Contact Name:		Relationship:		Phone:	
My child may carry and is trained to self-administer their allergy medication ☐ Yes ☐ No Provide extra for office ☐					
My child may carry and is trained to self-administer their rescue inhaler ☐ Yes ☐ No Provide extra for office ☐					

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care 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.
- Medical information may be shared with school staff working with my child and EMS if they are called.
- I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatment in accordance with the licensed healthcare provider's (LHP) instructions.
- This care plan includes a medication order, which should be discontinued by the LHP if or when appropriate.
- I authorize the exchange of information about my child's allergy between the LHP office and the school nurse.

I have reviewed and agree with this health care plan/504 and medication/treatment order.

Parent/Guardian Signature

Date

For School District Nurse Only		504 Plan ☐
A Registered Nurse has completed a nursing assessment and developed this allergy 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 has 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