# ANAPHYLAXIS HEALTH PLAN & MEDICATION ORDERS

Click to place student picture here

**ALLERGY TO:** _____

| | | |
|---|---|---|
| Student Name: | Birthdate: | Plan # : of |
| School: | School Year: | Grade: |
| ☐Bus # ☐Walk ☐Drive ☐Sport/Activity/PE: | Height: | Weight: |

Student Has Asthma ☐ Yes ☐ No Date of Last Allergic Reaction: _____

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

**EYES:** ☐Itchy ☐Watery ☐Swelling

**GENERAL:** ☐Panic ☐Sudden Fatigue ☐Chills ☐Fear ☐Impending Doom

**OTHER:** _____

**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:***

1. ☐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
2. Call 911 – Advise EMS that epinephrine has been administered
3. Stay with student
4. After epinephrine administered, administer _____ (antihistamine) _____(mg, ml)
5. 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
6. Notify school nurse and parent/guardian
7. 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: **<u>increased heart rate</u>** Antihistamine: **<u>sleepiness</u>**

Albuterol/Levalbuterol: **<u>increased heart rate, shakiness</u>**

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

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

# ANAPHYLAXIS HEALTH PLAN – PART 2 – 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 educational team and provided to staff as needed.
- My signature below shows that I have reviewed and agreed with this Health /504 Plan and medication/treatment orders.

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

**Student** (for all students but required for student who self-carries/self-administers rescue inhaler and/or epinephrine):

- 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 available to all staff members who are involved with the student, including substitutes.**