ANTIHISTAMINE 1st-- EAI CARE PLAN & MEDICATION ORDERS/504

ALLERGY (No History of Anaphylaxis)

Place student picture here

Plan: _____/_____Date plan created: _____ Date plan revised: _____ Weight: Height:

NAME:	**Birthdate:**	**PE/Sport:**

Grade:	**School:**	☐ **Bus #** ☐ **Walk** ☐ **Drive**
Doctor:	**Phone:**	**Fax:** **Preferred Hospital:**

History (including current medication):

Antihistamine location ☐ Office ☐ Backpack ☐ On person ☐ Other:_____

Epinephrine auto-injector(s) (EAI) location ☐ Office ☐ Backpack ☐ On person ☐ Other:_____

Licensed Health Professional (LHP) Orders / Care Plan for Allergy

If you suspect an exposure to _____ (allergen/s), treat the reaction as follows:

1. Medication Doses

Antihistamine _____cc/mg	Give: _____ Teaspoons _____ Tablets, by Mouth Repeat Dose: _____ (when) Side Effects: _____

2. **CALL SCHOOL NURSE AND PARENT/GUARDIAN**
3. **IT MAY BE NECESSARY FOR PARENT/GUARDIAN TO TAKE STUDENT HOME.**

SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY.
Some Symptoms can be life-threatening! ACT FAST!
****SEE BELOW IF SYMPTOMS PROGRESSES****
STUDENT HAS EPINEPHRINE AUTO-INJECTOR AVAILABLE

ANAPHYLAXIS IS HIGHLY LIKELY WHEN THE FOLLOWING CRITERIA ARE FULFILLED:

Onset of an illness (minutes to several hours), with involvement of the skin, after exposure to a *likely* allergen for that student: (eg. Generalized hives, itching, or flushing):

AND/OR AT LEAST ONE OR MORE OF THE FOLLOWING:

- Respiratory compromise (e.g. shortness of breath, wheeze, blue around lips & nail beds)
- Reduced blood pressure (e.g. weakness [collapse], dizziness, incontinence)
- Increased Involvement of the skin-oral tissue (e.g. generalized hives, itch-flush, swollen-lips-tongue-uvula)
- Persistent abdominal symptoms (e.g. crampy abdominal pain, vomiting)

If student has symptoms that progress into anaphylaxis:

1. Administer 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
2. Call 911 – Advise EMS that Epinephrine has been administered
3. Stay with student
4. After EAI administered, administer _____ (antihistamine) _____ (mg)
5. If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EAI, 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 an EAI must be monitored by medical personnel or a parent/guardian and may NOT remain at school
   - ☐ Student may carry EAI and/or antihistamine
   - ☐ Student has demonstrated EAI use in LHP's office
   - ☐ Student may self-administer EAI and/or antihistamine
   - ☐ Student has demonstrated inhaler use LHP's office
   - ☐ Student may carry and self-administer Inhaler

SIDE EFFECTS of medication(s):

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

EAI: increased heart rate. _____ Antihistamine: sleepy _____ Albuterol/Levalbuterol: increased heart rate, shakiness

_____(Allergy) Care Plan – Part 2 – Parent/Guardian (STUDENT): _____

BUS-TRANSPORTATION should be alerted to student's allergy.

◇ This student carries Rescue Medications on the bus: ☐ Yes ☐ No

◇ Medications can be found in ☐ Backpack ☐ Waistpack ☐ On Person ☐ Other (specify) ____

◇ Student will sit at front of the bus ☐ Yes ☐ No

FIELD TRIP Procedures – Medications must accompany student during any off campus activities.

◇ The student should remain with the teacher or parent/guardian during the entire field trip ☐ Yes ☐ No

◆ Staff members on trip must be trained regarding Epi-pen® use and this health care plan (plan must be taken).

CLASSROOM --For Food allergy only

◇ This student is allowed to eat only the following foods: ____

☐ Those in manufacturer's packaging with ingredients listed and determined allergen-free by the nurse/parent/guardian or ____

☐ Those approved by parent/guardian.

☐ Middle school or high school student will be making his/her own decision.

☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.

☐ Parent/guardian should be advised of any planned parties as early as possible.

☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens.

◇ Student should have someone accompany him/her in the hallways. ☐ Yes ☐ No

CAFETERIA ☐ **NO Restrictions**

☐ Student will sit at a specified allergy table.

☐ Student will sit at the classroom table cleansed according to procedure guidelines prior to student's arrival and following student's departure.

☐ Student will sit at the classroom table at a specified location.

◆ Cafeteria manager and hostess should be alerted to the student's allergy.

EMERGENCY CONTACTS

Parent/Guardian	Name		**Parent/Guardian**	Name	
	Primary #			Primary #	
	Other #			Other #	
	Other #			Other #	

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

My child may carry and is trained to self-administer their EAI	☐ Yes	☐ No	Provide extra for office	☐ Yes	☐ No
My child may carry and is trained to self-administer their antihistamine	☐ 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 EAI (needs assistance to administer)	☐ Yes	☐ No			

◆ I request this medication to be given as ordered by the licensed health professional (i.e.: doctor)

◇ I give Health Services Staff permission to communicate with the medical office about this medication. I understand that all medication will not necessarily be administered by a school nurse. It may be administered by school staff that have trained and are supervised by the school nurse.

◇ I release school staff from any liability in the administration of this medication at school.

◇ Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.

◇ All medication supplied will come in its originally provided container with instructions as noted above by the licensed health professional.

 This permission to possess and self-administer an Epinephrine auto-injector may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature Date

For District Nurse's Use Only:

Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication.
Device(s) if any, used_____ Expiration date(s): _____

School Nurse Signature Phone: Date

The RN has completed a nursing assessment and developed this Care Plan in conjunction with this student, their parent/guardian and their LHP.

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.