Fife School District Special Services

LIFE THREATENING ALLERGY EMERGENCY MEDICAL PLAN

Confidential Information 2026-27 School Year

Photo

Name:		Severe Allergy to:	
School:	Grade:	Birth Date:	**Asthma?** (High risk for severe reaction) ☐ **Yes** ☐ **No**

MEDICATION ORDERS

EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:

Call 911 if EPI-Pen is Administered

Epinephrine auto injector: ☐ (0.3mg) ☐ (0.15mg)	Side Effects: **Nausea, Vomiting, Shaking, Dizziness, Sweating**
Repeat Dose of Epinephrine: ☐ NO ☐ **YES** → **Repeat Dose**: If NO Improvement in: ☐ 5 Min ☐ 15 Min ☐ Other_____	
If a **REPEAT** dose of Epinephrine is ordered: Parent **MUST Provide: 2 Epinephrine Auto-injectors** for school	
Self Carry: ☐ Yes ☐ No	Med/Dose:

- ♦ It is medically necessary for this student to carry Epinephrine during school hours. ☐ Yes ☐ No
- ♦ Student has been trained and demonstrated appropriate use of Epinephrine to LHCP: ☐ Yes ☐ No
- ♦ Student may, per LHCP direction, self-administer Epinephrine. ☐ Yes ☐ No

Licensed **H**ealth **C**are **P**rovider's Signature: (and IHP team member)	Date:	
LHCP's Printed Name:	Phone:	Fax:

- I request the medication specified above be **given as ordered by the licensed health care provider**.
- All medication supplied must come in the **original provided container** with above instructions noted by the licensed health care provider.
- I understand the above medication(s) **may not always be given by a school nurse**. Trained and supervised designated staff are available when the nurse is not.
- I give Health Services Staff permission **to communicate with the medical office** about this medication.
- Medical/Medication **information may be shared with school staff** working with my child and 911 staff, if they are called.

Parent/Guardian Signature: _____ Date: _____

ACTION PLAN

☐ **DO NOT HESITATE:** Immediately **administer Epinephrine Auto-injector** when severe allergic reaction is suspected.
- **NOTE TIME**_____ **(Epinephrine given)**
- **NOTE TIME**_____ **(Antihistamine given)**

☐ **CALL 911 and parent/guardian.** Advise 911: Epinephrine has been given to a student.

☐ Adult to stay with student, monitor and begin CPR if necessary, stay until EMS arrives.

☐ Call the School Nurse at: _____ and notify building administrator.

☐ Give Epi auto-injector and copy of this Emergency Medical Plan to the EMS.

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Individual Health ACCOMMODATION PLAN for School

Transportation: Bus #: ☐ Car ☐ Walk	Date of **last reaction**: Previous Symptoms:
Medications at school: ☐ Epi-auto injector ☐ Inhaler ☐ Antihistamine	**Epinephrine** auto injectors are **stored**: ☐ Health Room ☐ Other:
Other Medications:	Other Allergies:

Classroom Parties, Snacks and Special Events: (For food allergies only)
Be aware of food being brought into the classroom as they might contain traces of the food allergen.
If you are unsure of a food item - for this student: **Read the label**.
During these events:
Does student require a specific eating location:

Transportation: Student carries an Epinephrine auto-injector on the bus? ☐ yes ☐ No

Field Trip: On a field trip: tell the nurse in advance; carry Epi-auto injector and be prepared to administer it. If Epi-auto injector is administered: Stay with student, call 911, notify parents and school nurse. Give Medical Plan and Epi-auto injector to medical responders.
Should student remain with teacher or family member during entire field trip**?** ☐ Yes ☐ No, ok to be with an adult chaperone

Other accommodations as deemed appropriate:

Teachers: Please place a copy of this plan in your **substitute folder**.

ACTION PLAN

If it **appears** that this student is having a **difficult time breathing** and is in **distress**, call the office. **Administer: Epi-auto injector**, and stay with the student. **Notify: 911**, parents, school nurse and building administrator. **Give: Medical plan** and Epi-auto injector(s) to the medical responders.

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
STOMACH	Nausea, stomach ache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

- Team members agree this severe allergy **substantially impairs** a major life activity and is **eligible** for Section 504.
- **Various sources of information were considered**: Medical information from LHCP, Parent, Nurse and academic setting.
- Fife School District recommends that your student wear a medical alert bracelet at all times.

Parent/Guardian, Health Team Member: _____ Date: _____

School Nurse, Health Team Member: _____ Date: _____

The information from this plan will be shared with: Parent, Teacher(s), Principal, Office Staff, Transportation, and Food Service. Other:(Elementary: Specialists and Recess Personnel) (Coaches when applicable).

If sent electronically to school staff, the signed original is kept in the Health Room.