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: _____ Height: _____ Weight: _____

Provider: _____ Phone: _____ Preferred Hospital: _____

☐Student Has Asthma 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

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:

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 administer _____ (antihistamine) _____ (mg)
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: **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.