

# SEVERE ALLERGIC REACTION/504 PLAN & MEDICATION ORDERS

Place Student picture here

Student has severe allergy to: \_\_\_\_\_

Nurse phone: \_\_\_\_\_

Date Plan Developed/Revised/Reviewed: \_\_\_\_\_

<b>NAME:</b> _____		<b>Birthdate:</b> _____	
<b>Grade:</b> _____	<b>School:</b> _____	<input type="checkbox"/> <b>Bus</b>	<input type="checkbox"/> <b>Walk</b> <input type="checkbox"/> <b>Drive</b>
<b>Allergy History:</b> <input type="checkbox"/> History of anaphylaxis/severe reaction <input type="checkbox"/> Skin testing indicates allergy		<b>Date of Last Reaction:</b> _____	
<b>Other Allergies:</b> _____		<input type="checkbox"/> <b>Student has Asthma</b> (increased risk factor for severe reaction)	
Epi auto-injector(s) location: <input type="checkbox"/> OFFICE <input type="checkbox"/> BACKPACK <input type="checkbox"/> ON PERSON <input type="checkbox"/> OTHER: _____			
Inhaler(s) location: <input type="checkbox"/> OFFICE <input type="checkbox"/> BACKPACK <input type="checkbox"/> ON PERSON <input type="checkbox"/> OTHER: _____			
<b>Anaphylaxis (Severe allergic reaction)</b> 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. <b>Do not hesitate to give Epi auto-injector and call 911.</b>			
<b>USUAL SYMPTOMS of an allergic reaction:</b>			
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		GUT--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			

## This Section To Be Completed By A Licensed Healthcare Provider (LHP):

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

1. Give Epi auto-injector     0.3 mg                                     Jr. 0.15 mg  
 **May repeat Epi auto-injector (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived.**

Document time medications were given below and alert EMS when they arrive.

\_\_\_\_\_                                    \_\_\_\_\_                                    \_\_\_\_\_                                    \_\_\_\_\_  
Epi-pen #1                                    Epi-pen #2                                    Antihistamine                                    Inhaler

2. Stay with student.
3. CALL 911 – Advise EMS that student has been given Epinephrine
4. Notify parents and school nurse.
5. After Epi auto-injection given, give Benadryl® or antihistamine \_\_\_\_\_ (ml/mg/cc)
6. If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction,  
After Epi auto-injection and antihistamine, may give:  
 Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®)                                     Albuterol/ Levalbuterol unit dose SVN (per nebulizer)  
 Levalbuterol 2 puffs (Xopenex®)                                     Other \_\_\_\_\_
7. A Student given an Epi auto-injector must be monitored by medical personnel or a parent & may NOT remain at school.

### SIDE EFFECTS of medication(s):

Epi auto-injector: **increased heart rate,** \_\_\_\_\_                                    Antihistamine: **sleepy,** \_\_\_\_\_

Albuterol/Levalbuterol: **increased heart rate, shakiness,** \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Student may carry & self administer Epi auto-injector +/- or antihistamine | <input type="checkbox"/> Student has demonstrated Epi auto-injector use in LHP's office |
| <input type="checkbox"/> Student may carry & self administer Inhaler                                | <input type="checkbox"/> Student has demonstrated inhaler use LHP's office              |

### PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY (required by USDA) Food Guidelines

Check here if student will EAT school provided meals during the entire school year. If so, one of the following must be completed.

1. Foods to omit: \_\_\_\_\_

Suggested general substitutions: \_\_\_\_\_

2.  Check here if standard substitutions offered in our district are acceptable. (Contact district Food Services Manager for details.)

**Note: Meals from home provide the safest food option at school.**

LHP Signature: _____		Print Name: _____	
Start date: _____	End date (not to exceed current school year): _____	<input type="checkbox"/> Last day of school	<input type="checkbox"/> Other: _____
Date: _____	Telephone #: _____	Fax #: _____	

Student: \_\_\_\_\_

## Care Plan for Severe Allergy – Part 2 – Parent

### Brief Medical History \_\_\_\_\_

#### Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
- Parent/guardian should be notified of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- Student is responsible for making his/her own food decisions.  Yes  No
- When eating student requires:  Specified eating location. Where? \_\_\_\_\_  
 No restrictions
- Other \_\_\_\_\_

#### Bus Concerns –Transportation should be alerted to student’s allergy.

- This student carries Epi auto-injector on the bus?  Yes  No Where? \_\_\_\_\_
- Epi auto-injector can be found in  Backpack  Waist pack  On Person  Other (specify) \_\_\_\_\_
- Student will sit at front of the bus?  Yes  No
- Other (specify) \_\_\_\_\_

#### Field Trip Procedures – Epi auto-injector must accompany student during any off campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip?  Yes  No
- Staff members on trip must be trained regarding Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify): \_\_\_\_\_

### EMERGENCY CONTACTS

<b>Mother/Guardian</b>	Name _____	<b>Father/Guardian</b>	Name _____
	Home Phone _____		Home Phone _____
	Work Phone _____		Work Phone _____
	Other _____		Other _____

### ADDITIONAL EMERGENCY CONTACTS

1. _____	Relationship: _____	Phone: _____
2. _____	Relationship: _____	Phone: _____

My student may carry and is trained to self-administer his/her own Epi auto-injector: <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide extra for office? <input type="checkbox"/> Yes <input type="checkbox"/> No
My student may carry and use his/her asthma inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide extra for office? <input type="checkbox"/> Yes <input type="checkbox"/> No

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e.: doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHP/medical office staff about his medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.
- Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
  - ▶ I request and authorize my child to carry and/or self-administer their medication.  Yes  No
  - ▶ This permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively 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

\_\_\_\_\_  
Date