Plan effective for school year:

SEVERE ALLERGY to _____

Never send student with allergic symptoms anywhere alone

Student Name: Grade: DOB:

Student Photo

Parent/Guardian: Home: Work:

Cell:

Home: Work:

Cell:

Emergency Contact: Phone:

Physician: Phone:

Current Medication:

Allergies:

SIGNS of a SEVERE ALLERGIC REACTION

Systems	Signs
Mental	States feels "scared, something bad is going to happen"
Mouth	Itching and swelling of the lips, tongue, or mouth
Throat	Itching or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	Hives, flushing, swelling about the face or extremities
Gut	Nausea, stomach cramps, vomiting, diarrhea
Lung	Shortness of breath, repetitive coughing, and or wheezing
Heart	Rapid heart rate, lightheaded, dizzy, loss of consciousness

IF YOU SEE THIS	DO THIS	TIME Initials
Following exposure to _____: ▪ Hives ▪ Swelling ▪ Difficulty breathing ▪ _____	▪ Give **Epi-pen** in outer thigh—kept _____. ▪ **Call 911** ▪ Call parent ▪ Adult stay with student, reassure and observe for worsening of condition.	
Breathing stops	▪ Begin CPR, elevate legs	

Note time of arrival and departure of ambulance; send a copy of form with the ambulance.

A copy of this plan will be kept in the school office and copies will be given to bus and PE/athletic department staff. Teachers will be notified that student has a plan on file in the office. The following staff have been trained to deal with an emergency, and initiate the appropriate procedures as described above. Signature by parent indicates agreement with this plan.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

_____, RN Date | _____ Parent Signature Date | _____ Physician Signature Date

inted 5/30/2007

Care Plan for Severe Allergy – Part 2 – Parent

Student Name: _____

Brief Medical History _____

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian. ☐ Yes ☐ No
- 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

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

- This student carries Epinephrine auto-injector (EAI) on the bus? ☐ Yes ☐ No
- EAI can be found in ☐ Backpack ☐ Waist pack ☐ On Person ☐ Other (specify) _____
- Student will sit at front of the bus? ☐ Yes ☐ No

Field Trip Procedures – EAI 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 EAI use and this health care plan (plan must be taken).

I wish to meet with the building 504 team to discuss additional accommodations ☐ Yes ☐ No

EMERGENCY CONTACTS

Parent/Guardian		Parent/Guardian	
Name		Name	
Home Phone		Home Phone	
Work Phone		Work Phone	
Other		Other	

ADDITIONAL EMERGENCY CONTACTS

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

My child may carry and is trained to self-administer his/her own EAI:	☐ Yes	☐ No	Provide extra for office?	☐ Yes	☐ No
My child may carry and use his/her asthma inhaler	☐ Yes	☐ No	Provide extra for office?	☐ Yes	☐ 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 this plan and medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and monitored school staff.
- I release school staff from any liability in the administration of this medication at school.
- I understand this is a life threatening plan and can only be discontinued, in writing, by the prescribing LHP.
- 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 LHP.
- I understand that my child 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 School Registered Nurse's Use Only

This student has demonstrated to the nurse, the skill to use the medication and any device necessary to administer the medication ordered whether self-administered or not. This plan has been reviewed/approved by a registered nurse.

Device(s) if any, to be used _____ Expiration date(s): _____

Registered Nurse Signature _____ Phone _____ Date _____

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members involved with the student.

Part 1 Licensed Health Care Provider Portion
Please complete on other side

SEVERE ALLERGY REACTION/504 PLAN & MEDICATION ORDERS

Montesano School District Fax #s: 360.841.7527 Jr./Sr. HS; 360.841-7528 Simpson; 360.841.7526 Beacon

Student has severe allergy to:

Place student picture here

Student Name: | Birthdate: | Weight:

Grade: | School: | ☐ Bus # ☐ Walk ☐ Drive

Allergy History: ☐ History of anaphylaxis/severe reaction ☐ Skin testing indicates allergy Date of Last Reaction:

Other Allergies: ☐ Student has Asthma (increased risk factor for severe reaction)

Epinephrine auto-injector (EAI) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER:

Inhaler(s) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER:

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 EAI and call 911.

USUAL SYMPTOMS of an allergic reaction: (Students usual s/s are in bold, italics, and/or underlined)

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

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 Epinephrine Auto Injector (EAI) ☐ 0.3 mg ☐ Jr. 0.15 mg
   ☐ May repeat EAI (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.
   _____ EAI #1 _____ EAI #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 EAI 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 EAI, administer:
   ☐ 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 EAI must be monitored by medical personnel or a parent and may NOT remain at school.

SIDE EFFECTS of medication(s):

EAI: Increased heart rate, _____ Antihistamine: sleepy, _____

Albuterol/Levalbuterol: Increased heart rate, shakiness, _____

☐ Student may carry & self-administer EAI +/or antihistamine ☐ Student has demonstrated EAI use in LHP's office
☐ Student may carry & self-administer inhaler ☐ 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: | LHP Print Name:

Start date: | End date | ☐ Last day of school | ☐ Other:

Date: | Telephone #: | Fax #:

Part 2 Parent Portion
Please complete on other side