

LIFE-THREATENING ALLERGY CARE PLAN
LAKE CHELAN SCHOOL DISTRICT #129

School _____ Year _____

Place
student
picture
here

NAME:			Severe ALLERGY to:	
			Other Allergies:	
Please list the specific symptoms the student has experienced in the past:			Asthma? <input type="checkbox"/> Yes (High risk for severe reaction) <input type="checkbox"/> No	
School:	Date of Birth:	Grade:	Routine medications (at home/school):	
Bus #	Car <input type="checkbox"/>	Walk <input type="checkbox"/>	Date of last reaction:	
Location(s) where EpiPen®/Rescue medications is/are stored:				
<input type="checkbox"/> Office <input type="checkbox"/> Backpack <input type="checkbox"/> On Person <input type="checkbox"/> Coach <input type="checkbox"/> Other _____				

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 |
| GUT | Nausea, stomachache/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 |

MEDICATION ORDERS

EpiPen® (0.3) <input type="checkbox"/>	EpiPen Jr.® (0.15) <input type="checkbox"/>	Side Effects:
Repeat dose of EpiPen®: <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, when
Antihistamine: _____cc/mg		Give: _____ Teaspoons _____ Tablets by mouth
Side Effects:		
♦ I request and authorize my child to carry and/or self-administer their medication. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ It is medically necessary for this student to carry an EpiPen® during school hours. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ Student may self-administer EpiPen®. <input type="checkbox"/> Yes <input type="checkbox"/> No ♦ Student has demonstrated use to LHCP. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Licensed Health Care Provider’s Signature:		Date:
Licensed Health Care Provider’s Printed Name:		Phone: Fax Number:

ACTION PLAN

- GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.
- NOTE TIME _____AM/PM (EpiPen®/adrenaline given) ♦ NOTE TIME _____AM/PM (Antihistamine given)
- CALL 911 IMMEDIATELY. 911 must be called WHENEVER EpiPen® is administered.
- DO NOT HESITATE to administer EpiPen® and to call 911 even if the parents cannot be reached.
- Advise 911 student is having a severe allergic reaction and EpiPen® is being administered.
- Call the School Nurse or Health Services Main Office at _____.
- Student should remain with a staff member at the location where symptoms began until EMS arrives.
- Notify the administrator and parent/guardian.
- Dispose of used EpiPen® in “sharps” container or give to EMS along with a copy of the Care Plan

Individual Considerations

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

- ◆ This student carries Epipen® on the bus: Yes No
 - If NO, permission to ride the school bus without Epi Pen, releasing the school from any liability Yes
- ◆ Epipen® can be found in: Backpack Waistpack On Person Other (specify) _____
- ◆ Student will sit at front of the bus: Yes No
- ◆ Other (specify): _____

Field Trip Procedures – Epipen® should accompany student during any off campus activities.

- ◆ Student should remain with the teacher or parent/guardian during the entire field trip: Yes No
- ◆ Staff members on trip must be trained regarding Epipen® use and student health care plan (plan must be taken).
- ◆ Other (specify) _____

CLASSROOM – For Food allergy only

- Student is allowed to eat only the following foods: _____
- Those in manufacturer’s packaging with ingredients listed and determined allergen-safe by the parent or _____
- Those approved by parent only
- 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
- Other (specify): _____

CAFETERIA **NO Restrictions**

- Student will sit at a specified allergy table. (Elementary School Only)
- Cafeteria manager and hostess should be alerted to the student’s allergy.
- Other: _____

EMERGENCY CONTACTS

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

- ◆ I request this medication to be given as ordered by the licensed health care provider.
- ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- ◆ 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 care provider.
- ◆ This permission to possess and self-administer an EpiPen® 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
School Nurse Signature	Date

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.