Madison School District 321

Allergy & Anaphylaxis Action Plan
Individualized Health Care Plan (IHC)

School Year:	Student Picture
School:	
Grade:	

STUDENT INFORMATION

Student:		DOB:
Parent:	Phone:	Email:
Parent:	Phone:	Email:
Healthcare Provider:	Phone:	Fax:
District Nurse: Kim Ward , RN	Phone: 503-871-2834	Fax: 208-359-3370

Asthma: ◯ No
◯ Yes (if yes, high risk for severe reactions, please also complete Asthma Action Plan)

SPECIAL CONSIDERATIONS

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

ALLERGEN(S)

please check all that apply:

◯ peanuts	◯ wheat	◯ latex
◯ tree nuts	◯ eggs (safe to have in baked goods)	◯ animals
◯ soy	◯ eggs (NOT safe to have in baked goods)	◯ medication (specify):_____
◯ fish	◯ dairy (safe to have in baked goods)	◯ insect stings (specify):_____
◯ shellfish	◯ dairy (NOT safe to have in baked goods)	◯ other :_____

◯ If checked, administer EPI PEN immediately if exposure to allergen LIKELY occurred, for ANY symptoms.
◯ If checked, administer EPI PEN immediately if exposure to allergen DEFINITELY occurred, even if not symptomatic.

ACTIONS FOR MILD TO MODERATE ALLERGIC REACTION

MILD Symptoms

Nose - itchy/runny nose
Mouth - itchy mouth
Skin - a few hives, mild itch
Gut - mild nausea/discomfort, one episode of mild vomiting (not repetitive)

** **For a *single* MILD SYMPTOM (listed at left), follow the directions below:**

1. Antihistamines may be given (ie. Benadryl), if ordered by a healthcare provider (see 2nd page).
2. Stay with student; call parent/guardian/emergency contacts.
3. If parent/guardian/emergency contacts are not available within 15 minutes and symptoms persist, call 911.
4. If symptoms worsen, give EPI PEN, have someone else call 911, & stay with student!

** **For *more than one* MILD SYMPTOM (ie. itchy mouth & nausea), GIVE EPI PEN!**

ACTIONS FOR SEVERE ALLERGIC REACTION (ANAPHYLAXIS)

SEVERE Symptoms

Lung - short of breath, wheezing, repetitive cough
Heart - pale, blue, faint, weak pulse, dizzy
Throat - tight, hoarse, trouble breathing or swallowing
Mouth - significant swelling of the tongue and/or lips
Skin - many hives over body, widespread redness
Gut - repetitive vomiting, severe diarrhea
Other - feeling something bad is about to happen, anxiety, confusion

For ANY SEVERE symptom (listed left), follow directions below:

1. **INJECT EPI PEN IMMEDIATELY!**
2. Have someone else **Call 911. STAY WITH STUDENT!**
3. Consider giving additional medication ***following* EPI PEN.**
   * Antihistamine (ie. Benadryl) - see 2nd page
   * Asthma Inhaler, if wheezing - see 2nd page
4. Lay the person flat, raise legs, and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on side.
5. If symptoms do not improve, or symptoms return, EPI PEN can be given five minutes or more after 1st dose.

MEDICATION - a separate Medication Request Form is required for each medication

Epinephrine Brand:	Dose:	Side Effects:
Antihistamine Name:	Dose:	Side Effects:
Other: (eg, asthma inhaler)	Dose:	Side Effects:

LOCATION OF EPINEPHRINE - please mark all that apply

◯ Backpack ◯ In Classroom ◯ Office ◯ Other _____

PARENT TO COMPLETE

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.
* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.
* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication as directed.
* I agree to release, indemnify, and hold harmless the District Nurse and other designated staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with allergy treatment, provided the personnel are following physician instruction as written in the emergency action plan above.
* I understand I am responsible for maintaining necessary supplies, medication, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form and Emergency Care Plan Form must be completed before the school staff can administer the medication.
* I understand that if any emergency medication is administered at school, EMS will be notified for evaluation, monitoring, and possible further treatment.
* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive. I understand that if I want my child to remain in school after receiving emergency medication, I will have to stay with him/her at school.

Parent Name:	**Phone:**
Parent Signature:	**Date:**

HEALTHCARE PROVIDER TO COMPLETE - please read, check one of the options, and sign below

◯ It is **medically appropriate** for the student to **self-carry and self-administer** the Epinephrine Auto Injector (EAI) medication, when able and appropriate, and should be in possession of EAI medication at all times.
***** The student has been trained and has demonstrated proper medication administration procedure.***

◯ It is **medically appropriate** for the student to self-carry EAI, **but NOT self-administer** EAI. Please have the designated school personnel administer this student's medication in an emergency.

◯ It is **NOT medically appropriate** for the student to **self-carry or self-administer** this EAI medication. Please have the designated school personnel maintain and administer this student's medication in an emergency.

This student is under my care. This Allergy & Anaphylaxis Action Plan reflects my plan of care.

Healthcare Provider Name:	**Phone:**
Healthcare Provider Signature:	**Date:**
District Nurse:	**Date:**