

**2022-2023 ALLERGY CARE PLAN AND MEDICATION ORDERS****No History of Anaphylaxis**

Plan \_\_\_\_ of \_\_\_\_

Place  
student  
picture  
here

|                 |   |                                |  |
|-----------------|---|--------------------------------|--|
| STUDENT NAME    |   | Birthdate                      |  |
| Grade           | School  | <input type="checkbox"/> Bus # | <input type="checkbox"/> Walk <input type="checkbox"/> Drive |
| Other Allergies | <input type="checkbox"/> Student has Asthma (increased risk factor for severe reaction) |                                |  |

Date of last reaction:

Brief medical history :

|                        |                                 |                                   |                                    |                                      |
|------------------------|---------------------------------|-----------------------------------|------------------------------------|--------------------------------------|
| Antihistamine 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 _____ |

**This Section to be Completed by a Licensed Healthcare Provider (LHP)**

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

- Administer: \_\_\_\_\_ (antihistamine) \_\_\_\_\_ (mg)  
☐ May repeat antihistamine dose after \_\_\_\_\_ minutes  
Antihistamine side effects: ☐ Drowsiness ☐ Hyperactivity ☐ Other: \_\_\_\_\_
- If student has asthma and is coughing, wheezing, short of breath, and/or has chest tightness, administer:  
☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Other \_\_\_\_\_  
☐ May repeat every \_\_\_\_\_ minutes as needed for symptoms
- Call school nurse and parent/guardian.
- Student may carry and is trained to self-administer antihistamine. ☐ Yes ☐ No
- Student may carry and is trained to self-administer rescue inhaler. ☐ Yes ☐ No

**SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY**  
**Some Symptoms can be life-threatening—ACT FAST**  
**IF SYMPTOMS INCREASE – DON'T HESITATE TO CALL 911****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 call 911.****USUAL SYMPTOMS of an anaphylactic reaction:**

MOUTH—Itching, tingling, or swelling of the lips, tongue, or mouth

SKIN—Hives, itchy rash, and/or swelling about the face or extremities

GENERAL—Panic, sudden fatigue, chills, fear of impending doom

HEART—"Thready" pulse, "passing out", fainting, blueness, pale

LUNG—Shortness of breath, repetitive coughing, and/or wheezing

GUT—Nausea, stomach ache/abdominal cramps, vomiting, diarrhea

THROAT—Sense of tightness in the throat, hoarseness, hacking cough

- CALL 911 – if symptoms increase
- Advise EMS that antihistamine has been administered and no epinephrine is available
- Notify school nurse and parent/guardian of change in condition

**\*\*\*\*\* If student has a food allergy, please complete Request for Special Dietary Accommodations and Attachment A: Foods to be Omitted and Substituted form \*\*\*\*\***

|               |           |   |                                |
|---------------|-----------|---|--------------------------------|
| LHP Signature |           | LHP Print Name                              |                                |
| Start date    | End date  | <input type="checkbox"/> Last day of school | <input type="checkbox"/> Other |
| Date          | Telephone | Fax:  |                                |

**Allergy Care Plan – Part 2 – Parent/Guardian (STUDENT):** \_\_\_\_\_**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: Transportation staff should be alerted to student's allergy**

- Student carries allergy medication on the bus ☐ Yes ☐ No
- Medication can be found in ☐ Backpack ☐ On person ☐ Other (specify) \_\_\_\_\_
- Student will sit at front of the bus ☐ Yes ☐ No
- Other (specify) \_\_\_\_\_

**Field Trip/Extracurricular Activity: Allergy medication must accompany student during any off-campus activity**

- 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 care plan (health care plan must also accompany student).

**Other accommodations** \_\_\_\_\_

- Does student need other classroom, school activity, or recess accommodations ☐ Yes ☐ No
- If yes, contact the school counselor or 504 coordinator

**EMERGENCY CONTACTS**

|  |           |                        |           |        |  |
|--|-----------|------------------------|-----------|--------|--|
| <b>Parent/Guardian</b>   | Name      | <b>Parent/Guardian</b> | Name      |        |  |
|  | Primary # |                        | Primary # |        |  |
|  | Other #   |                        | Other #   |        |  |
|  | Other #   |                        | Other #   |        |  |
| Name:  |           | Relationship:          |           | Phone: |  |
| My child may carry and is trained to self-administer their allergy medication <input type="checkbox"/> Yes <input type="checkbox"/> No Provide extra for office <input type="checkbox"/> |           |                        |           |        |  |
| My child may carry and is trained to self-administer their rescue inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No Provide extra for office <input type="checkbox"/>     |           |                        |           |        |  |

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care 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.
- Medical information may be shared with school staff working with my child and EMS, if they are called.
- I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatment in accordance with the licensed healthcare provider's (LHP) instructions.
- This care plan includes a medication order, which should be discontinued by the LHP if or when appropriate.
- I authorize the exchange of information about my child's allergy between the LHP office and the school nurse.

**I have reviewed and agree with this health care plan/504 and medication/treatment order.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

- I have demonstrated the correct use of the 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**

|  |  |  |
|--|--|--|
| <b>For School District Nurse Only</b>  |  | <b>504 Plan</b> <input type="checkbox"/> |
| A Registered Nurse has completed a nursing assessment and developed this allergy care plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication ordered above: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the student has demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Device(s) if any, Used   |  | Expiration date(s)                       |
|  |  |  |
| Registered Nurse Signature   |  | Date                                     |