

# 2022-2023 ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS

Place  
student  
picture  
here

Allergy to \_\_\_\_\_ Plan \_\_\_\_\_ of \_\_\_\_\_

STUDENT NAME

Birthdate

Grade \_\_\_\_\_ School \_\_\_\_\_ ☐ Bus # ☐ Walk ☐ Drive

Allergy History ☐ History of anaphylaxis Date of Last Reaction \_\_\_\_\_ Weight \_\_\_\_\_

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

Brief Medical History (including current medications)

Epinephrine auto-injector(s) (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: (please check those that are known/history for student)**

**MOUTH (Lips, Tongue):** ☐ Itching ☐ Tingling ☐ Swelling **THROAT:** ☐ Sense of tightness ☐ Hoarseness ☐ Hacking cough  
**GUT:** ☐ Nausea ☐ Stomach ache/cramps ☐ Vomiting ☐ Diarrhea **LUNG:** ☐ Shortness of breath ☐ Repetitive coughing ☐ Wheezing  
**SKIN:** ☐ Hives ☐ Itchy Rash ☐ Swelling of the face/extremities **HEART:** ☐ Thready pulse ☐ Passing out/Fainting ☐ Blueness ☐ Pale  
**GENERAL:** ☐ Panic ☐ Sudden Fatigue ☐ Chills ☐ Fear ☐ Impending doom

## **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 Epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg (Jr)  
☐ May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived
- Call 911 – Advise EMS that Epinephrine has been administered
- Stay with student
- After EAI administered, administer \_\_\_\_\_ (antihistamine) \_\_\_\_\_ (mg)
- If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EAI, administer  
☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)  
☐ Levalbuterol 2 puffs (Xopenex®) ☐ Other \_\_\_\_\_  
☐ May repeat every \_\_\_\_\_ minutes as needed for symptoms ☐
- Notify school nurse and parent/guardian
- A Student given an EAI must be monitored by medical personnel or a parent and may NOT remain at school  
☐ Student may carry EAI and/or antihistamine ☐ Student has demonstrated EAI use in LHP's office  
☐ Student may self-administer EAI and/or antihistamine ☐ Student has demonstrated inhaler use LHP's office  
☐ Student may carry and self-administer Inhaler

**SIDE EFFECTS of medication(s):**

EAI: \_\_\_\_\_ Antihistamine: \_\_\_\_\_

Albuterol/Levalbuterol: \_\_\_\_\_

**\*\*\*\*\* 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 ☐ Last day of school ☐ Other

Date

Telephone

Fax

## Anaphylaxis Care Plan – Part 2 – Parent/Guardian: STUDENT NAME \_\_\_\_\_

### 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 staff should be alerted to student's allergy

- Student carries Epinephrine auto-injector (EAI) on the bus/transportation ☐ Yes ☐ No
- EAI can be found ☐ On person ☐ Other (specify) \_\_\_\_\_ health room \_\_\_\_\_
- Student will sit at front of the bus ☐ Yes ☐ No
- Other (specify) \_\_\_\_\_

### Field Trip/Extracurricular Activity: *EAI must accompany student during any off campus activity*

- The 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 EAI		<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide extra for office <input type="checkbox"/> Yes <input type="checkbox"/> No
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"/> Yes <input type="checkbox"/> No
My child may carry their EAI (needs assistance to administer)		<input type="checkbox"/> Yes <input type="checkbox"/> No	

- 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 is a life-threatening care plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's severe 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 epi pen/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 \_\_\_\_\_

### For School District Nurse Only

504 Plan ☒

A Registered Nurse has completed a nursing assessment and developed this Anaphylaxis Care Plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication ordered above: ☐ Yes ☐ No If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: ☐ Yes ☐ No

Device(s) if any, used \_\_\_\_\_

Expiration date(s) \_\_\_\_\_

Registered Nurse Signature \_\_\_\_\_

Date \_\_\_\_\_

Phone \_\_\_\_\_