BARRINGTON PUBLIC SCHOOLS ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ DOB: _____ Teacher/Cluster: _____

Allergy to: _____

Weight: _____ lbs. **Asthma**: [ ] Yes (Higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy/bee sting/other allergic reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS:

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, or definitely stung, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilator) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **CALL 911**. Request ambulance with epinephrine.
   - Consider giving additional medications (following or with the epinephrine):
   - ➢ Antihistamine
   - ➢ Inhaler (bronchodilator), if asthma
   - Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
   - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
   - Alert emergency contacts.
   - Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten or likely stung.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATION/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15mg IM [ ] 0.3mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose:_____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

[_____] If initialed by Physician/HCP, student may self-carry and/or self-administer epinephrine.

_____
Parent/Guardian Authorization Signature **Date**

_____
Certified School Nurse Teacher Authorization Signature **Date**

_____
Physician/HCP Authorization Signature **Date**

_____
Please Print Physician Name **Phone**

Information will be shared with appropriate school & food service personnel

Form adapted from (FARE) Food Allergy Research & Education Rev. 5.2016

(**TURN FORM OVER**) ➡

BARRINGTON PUBLIC SCHOOLS PEANUT/NUT & FOOD ALLERGY INDIVIDUAL HEALTH CARE PLAN (IHCP)

Name: _____ **DOB**: _____ **Allergy to:** _____

Level of Allergy: (Circle) Inhalation Tactile Ingestion Unknown Age of Onset: _____

Describe symptom(s) of allergic reaction(s):_____

History of Anaphylaxis: (Circle one) Yes No **Treatment:** EpiPen Benadryl **Other: (please specify)** _____

Other health conditions/medications (e.g., Asthma): _____

Location of Epinephrine at school: Health Office (unlocked cabinet during regular school hours)_____

Preventive Measures

Signs shall be posted advising there is a student with allergies to peanuts/nuts. **Parent/Guardian Initials**

- Protections needed include a designated **peanut/nut free** classroom **and** lunch table. Initial - **Yes____ No____**
- Student will participate in the school lunch program. Initial - **Yes____ No____**
  - Before participation, the parent/guardian must inform the food service of their child's food allergy.
  - Contact Person: Chartwells Dining Services Director, Kimberley Orr Kimberley.Orr@compass-usa.com; (401) 253-1452; The School Nurse Teacher will provide further information as requested.

- Parent/guardian will inform bus company personnel of their child's allergy medication requirements, & emergency contact information. **Parent/Guardian Initials _____**

- Medications that are kept in the nurse's office are available during school hours only. For any before and after school activities, it is the parent/guardian responsibility to inform activity coordinator of their child's allergy, treatments & provide emergency medications. **Parent/Guardian Initials _____**

- School personnel who may be involved in the care of a student who has been diagnosed with an allergy will be informed of the EHCP and IHCP.
- All parents/guardians in the peanut/nut free classroom will be notified in writing by the school administrator of the peanut/nut free snack policy.
- Student will be reminded not to share or trade food.
- The student will be accompanied to the health office in the event of an allergic reaction
- Trained school personnel will carry the prescribed emergency medication(s), and a copy of the EHCP on the field trip and accompany student at all times if the parent is not present. NOTE: Student may self-carry with doctor orders.
- Other Provisions Required:_____

EMERGENCY CONTACTS (please print) **Treat student before calling Emergency Contacts. - CALL 911**

Parent/Guardian: _____ Phone: (____) _____-_____

Parent/Guardian: _____ Phone: (____) _____-_____

Other: Name/Relationship: _____ Phone: (____) _____-_____

_____

Physician/HCP Authorization Signature **Date**

_____

Parent/Guardian Authorization Signature **Date**

_____

Certified School Nurse Teacher Authorization Signature **Date**