LOWVILE CENTRAL SCHOOL DISTRICT

 Medical Management

Health Care Plan for Children with Potentially Severe Allergic Reactions

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergen(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Student’s picture, as available, and allergic information will be noted on account page of cafeteria computers, if food allergy.
2. Medical information regarding the allergies in general, and specifically for this child, will be shared with appropriate school staff.
3. The “Emergency Action Plan” will be provided to all the student’s teachers at the elementary level.
4. Have parents review and sign the “Allergy Action Plan.”, and Medical management Plan*.*
5. Have parents provide doctor’s orders to administer the EpiPen and antihistamine; i.e. Benadryl. Parents will provide doctor’s documentation stating the student’s allergies and allergen(s) involved (food, bees, latex, etc.).
6. Have parents provide EpiPen(s) and antihistamine if ordered.
7. Encourage the parents to have their child wear a medical alert bracelet.
8. Parents may wish to provide a box of “safe” snacks for the classroom teacher.
9. Have parents contact the District Food Service Director, at 376 – 9004, to discuss the menu if the student plans on buying food.
10. Have parents inform the child’s bus driver of their allergy and contact the Transportation Department at 376-7212 to advise them of their child’s special needs. In general, medications will NOT be available on the bus to and from school.
11. Parents will contact school authority/supervisor/coach in charge of before or after school activities to inform them of their child’s allergies.
12. Parent will collaborate/cooperate with school personnel in regard to their child attending field trips.
13. All EpiPens will be stored in the health office unless the parent chooses one of the following options:
* Option 1 – One EpiPen will be located in the health office and one in the primary classroom (at the elementary and MS level).
* Option 2 – One EpiPen will be located in the health office and one EpiPen will travel with the student.

 Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_

**Emergency Action Plan for Allergic Reaction Food**

**Copies of this plan will be shared with appropriate staff members.**

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Teacher/ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**ALLERGY TO**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthmatic \*Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ \*Higher risk for severe reaction

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STEP 1: TREATMENT Give checked medication:**

 **(To be determined by physician authorizing treatment)**

 **If a food allergen has been ingested, *but no symptoms…*** \_\_\_ Epi-Pen ***\_\_\_*** Antihistamine

 **If symptoms of**:

\*MOUTH itching and swelling of lips, tongue or mouth… \_\_\_ Epi-Pen \_\_\_ Antihistamine \*THROAT itching/sense of tightness in throat, hoarseness, hacking cough… \_\_\_ Epi-Pen \_\_\_ Antihistamine

\*SKIN hives, itchy rash, and/or swelling about the face or extremities… \_\_\_ Epi-Pen \_\_\_ Antihistamine

\*LUNGS shortness of breath, frequent coughing and /or wheezing,,, \_\_\_ Epi-Pen \_\_\_ Antihistamine

\*HEART “thready” pulse, faintness, pale, low blood pressure,,, \_\_\_Epi-Pen \_\_\_ Antihistamine

***The severity of symptoms can quickly change*.**

**DOSAGE:**

**EpiPen:** Inject intramuscularly (circle one) EpiPen ® EpiPen Jr. ® Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(see reverse side for instructions) Mediation/dose/route

A**ntihistamine/Benadryl: give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medication/dose/route

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication/dose/route

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL AMBULANCE IF APPARENT REACTION

**Step 2: Emergency Calls**

**1. Call ambulance: 911**  School Nurse: 376-9007 or extension: 1261

2. Call: Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Emergency Contacts:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE and TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_