ALLERGY/ANAPHYLAXIS CARE PLAN

Name_____ **Birthdate**_____ **Teacher** _____

School Nurse_____ **Phone**_____ **Fax**_____

Healthcare Provider_____ **Preferred Hospital** _____

Student Photo

HISTORY OF ASTHMA: ☐ **No** ☐ **Yes-*Higher risk for severe reaction***

ALLERGY: (check appropriate) ***To be completed by Healthcare Provider***

- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex:** ☐ **Type I (anaphylaxis)** ☐ **Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**
- ☐ **Other (list):**

RECOGNITION & TREATMENT:

Chart to be completed by Healthcare Provider ONLY		**Give CHECKED Medication**	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	☐ Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. + = Potentially life-threatening.			

DOSAGE:

- ✓ **Epinephrine:** Inject into outer thigh (through clothing) ☐ **0.3 mg** ***OR*** ☐ **0.15 mg**
- ✓ **Antihistamine:** ☐ **Loratadine**_____**mg** ☐ **Cetirizine**_____**mg** ☐ **Diphenhydramine**_____**mg**
  (Liquid or melts or depends which is available). ***To be given by mouth only if able to swallow.***

Other:

☐ **This child has received instruction in the proper use of the Auto-injector: EpiPen® or Auvi-Q® or** _____ **(circle one). It is my professional opinion that this student SHOULD be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.**

☐ **It is my professional opinion (HCP) that this student SHOULD NOT carry an auto-injector.**

☐ **This child has special needs and the following instructions apply**:_____

Healthcare Provider Signature_____ ***Phone:*** _____ ***Date*** _____

EMERGENCY PROTOCOL:

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

1. Call parents/guardian to notify of reaction, treatment and student's health status.
2. Treat for shock. Prepare to do CPR.

ALLERGY/ANAPHYLAXIS CARE PLAN

Side 2: To Be Completed by Parent/Guardian, Student and School
Allergy/Anaphylaxis Action Plan *(continued)* **Student Name** _____

Parent/Guardian AUTHORIZATIONS

- ☐ I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto-injector.
- ☐ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.
- ☐ I request that school staff be trained in to give emergency medications to my child in the absence of the nurse.

Parent is responsible for auto injectors for before and after school activities separate from the school day supply.
I understand that submission of this form may require the nurse to contact and receive additional information from the health care provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature: _____ **Phone**: _____ **Date**: _____

EMERGENCY CONTACTS	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

Student Agreement:

- I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;
- I agree to carry my auto-injector with me at all times;
- I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when my auto-injector (epinephrine) is used;
- I will not share my medication with other students or leave my auto-injector unattended;
- I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ **Date** _____

Approved by Nurse/Principal Signature: _____ **Date** _____

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis.

Critical components to prevent life threatening reactions: ☑ Indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies
	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex Reduced Environment" sign at entrance of building
	Encourage a No-Peanut Zone in the school cafeteria
	Other:

STAFF MEMBERS TRAINED

Name	*Title*	*Location/Room #*	*Trained By (RN only)*