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**
- ✓ **2nd Dose given** _____ **minutes after first**
- ✓ **Antihistamine: 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 Twinject® or Auvi-Q™ (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:

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. 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 must supply 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)*	*Date*