LIFE-THREATENING ALLERGY CARE PLAN

Name:			Severe allergy to:	
Date of Birth:			Other allergens:	
School:	Grade:		Routine medication (at home/school):	
Bus # ☐	Car ☐	Walk ☐	Date of last reaction:	Asthma: ☐ Yes ☐ No

Location(s) where EpiPen/Rescue medications is/are stored:

☐ Office ☐ Backpack ☐ On Person ☐ Other: _____

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911

Please check symptoms student has experienced in the past:

☐ **MOUTH** Itching, tingling or swelling of the lips, tongue, or mouth
☐ **SKIN** Hives, itchy rash, and/or swelling about the face or extremities
☐ **THROAT** Sense of tightness in the throat, hoarseness, and hacking cough
☐ **GUT** Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
☐ **LUNG** Shortness of breath, repetitive coughing, and/or wheezing
☐ **HEART** "Thready" pulse, "passing out", fainting, blueness, pale
☐ **GENERAL** Panic, sudden fatigue, chills, fear of impending doom
☐ **OTHER** Some student may experience symptoms other than listed above _____

MEDICATION ORDERS (To be completd by Licensed Health Care Provider-LHP)

EpiPen® 0.3 mg ☐ EpiPen Jr. ® 0.15mg ☐ Side effects:

☐ Repeat dose of EpiPen® in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived.

After EpiPen ® has been administered give: Antihistamine: _____, _____ ml, mg/cc

☐ If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EpiPen ® has been given, administer:

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Levalbuterol 2 puffs (Xopenex®)

- It is medically necessary for this student to carry an EpiPen® during school hours ☐ Yes ☐ No
- Student may self-administer EpiPen® ☐ Yes ☐ No
- Student has demonstrated use of LHCP ☐ Yes ☐ No

Licensed Health Care Provider's Signature:	Date:
Licensed Health Care Provider's Printed Name:	Phone
Start Date:	End date: ☐ Last day of school ☐ Other

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE, AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
- **NOTE TIME EPIPEN®/adrenaline GIVEN_____AM/PM / NOTE TIME ANTIHISTAMINE GIVEN _____AM/PM**
- **CALL 911 IMMEDIATELY, 911 must be called WHENEVER EpiPen® is administered.**
- **DO NOT HESITATE to administer EpiPen® and to call 911 even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and EpiPen® has been administered.
- An adult trained in CPR is to stay with student-monitor and begin CPR if necessary.
- Call the School Nurse or Health Services Main Office at _____.
  - Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
  - Notify the administrator and parent/guardian
  - Give used EpiPen® to EMS along with a copy of this Care Plan

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INDIVIDUAL CONSIDERATIONS for: Click or tap here to enter text.

Bus-Transportation should be alerted to student's allergy.

- This student carries EpiPen® on the bus: ☐ Yes ☐ No
- EpiPen® can be found in: ☐ Backpack ☐ On person ☐ Other: _____
- Student will sit at the front of the bus: ☐ Yes ☐ No
- Other (specify): _____

Field Trip Procedures-EpiPen® should accompany student during any off-campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: ☐ Yes ☐ No
- Staff members on trip must be trained regarding EpiPen® use and student health care plan (plan must be taken)
- Other (specify): _____

FOOD ALLERGY ACCOMMODATIONS:

Student is able to make their own food decisions: ☐ Yes ☐ No

When eating, student requires: ☐ Specified eating location, where: _____

☐ No restrictions ☐ Other: _____

☐ Food 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

☐ Other (specify): _____

EMERGENCY CONTACTS

Parent/guardian	Name	**Parent/guardian**	Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #

Name	Relationship	Phone

- I request this medication to be given as ordered by the licensed health care provider.
- I give Health Services Staff permission to communicate with the medical office regarding this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- Medical/Medication information may be shared with school staff working with my child and 911 staff if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.
- I request and authorize my child to carry and self-administer their medication: ☐ Yes ☐ No
- This permission to possess and self-administer an EpiPen® may be revoked by the principal/school nurse if it is determined that your child is not safely and effectivity able to self-administer.

Parent/Guardian signature: _____ Date: _____

Student demonstrated to the nurse the skill necessary to use the medication and any device necessary to self-administer the medication.

Devices used (if any): _____ Expiration date: _____

School Nurse Signature: _____ Date: _____