STUDEN	T ALLERGY/ANAPH	HYLAXIS CARE PLAN						
Student Na	me	D.O.B Teach	er	Student				
	chool NursePhone Number			Photo				
Health Care								
History of A	Asthma □ No □	Yes (Higher risk for severe re	eaction)					
ALLERGY: (check appropriate) TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY  □ Foods (list): □ Medications (list)								
□ Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)								
□ Stinging Insects (list): □ Other (list):								
RECOGNITION AND TREATMENT: To be completed by Health Care Provider ONLY			Give CHECKED Medication					
If food inges	ted or contact with allergen o	occurs:	Epinephrine	Antihistam	ine			
No symptom	is noted □ Observe for oth	ner 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 <b>+</b>	Shortness of breath, repetiti							
Heart+	Thready pulse, low BP, fain							
Neuro+	Disorientation, dizziness, lo							
If reaction is progressing (several of the above areas affected), GIVE:								
The severity	y of symptoms can quickly	change. + Potentially life-the	reatening					
<ul> <li>DOSAGE: TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY</li> <li>Epinephrine: Inject into outer thigh □ 0.3 mg OR □ 0.15 mg</li> <li>Antihistamine: Diphenhydramine (Benadryl®) mg (Liquid or Fastmelts). ONLY if able to swallow.</li> <li>Epinephrine Auto Injector will be used for a severe asthma episode at school, this may be given in addition to the student's prescribed medication or if the student does not have access to their prescribed medication.</li> <li>□ This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (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.</li> </ul>								
□ It is my professional opinion that this student <b>SHOULD NOT</b> carry the auto-injector. □ This child has special needs and the following instructions apply:  Health Care Provider Signature  Phone:  Date								
<del> </del>	· · · · · · · · · · · · · · · · · · ·							

## **ASD EMERGENCY PROTOCOL:**

- 1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
- Call parents/guardian to notify of reaction, treatment and student's health status.
   Treat for shock. Prepare to do CPR.

## Side 2: To Be Completed by Parent/Guardian, Student and School Allergy/Anaphylaxis Care Plan (continued) Student Name \_\_\_\_\_\_ D.O.B. \_\_\_\_\_ 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. □ Parent is responsible for auto-injectors for before and after school activities (there is no nurse available). EMERGENCY CONTACTS: NAME HOME# Work# CELL# PARENT/GUARDIAN PARENT/GUARDIAN OTHER: OTHER: I understand that submission of this form may require the Nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication. My signature below provides authorization for this contact. I also understand that a signature is mandatory for school acceptance of this form. Parent/Guardian Signature: \_\_\_\_\_Phone: \_\_\_\_\_ Date: \_\_\_\_\_ 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: Approved by Nurse, Signature: Date **PREVENTION:** Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions: $\sqrt{\text{Indicates activity completed by school staff}}$

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(s) of building				
Encourage a no-peanut zone in the school cafeteria				
Other:				

## STAFF MEMBERS TRAINED:

NAME	TITLE	LOCATION/ROOM	TRAINED BY (RN only)