

# SEVERE ALLERGIC REACTION PLAN & MEDICATION ORDERS

Nurse phone #: \_\_\_\_\_

Student has severe allergy to: \_\_\_\_\_

Place  
student  
picture  
here

NAME:	Birthdate:	Grade:	School:
<input type="checkbox"/> Bus # _____ <input type="checkbox"/> Walk? <input type="checkbox"/> Drive?			

Allergy History:  History of anaphylaxis/severe reaction     Skin testing indicates allergy    Date of Last Reaction: \_\_\_\_\_

Other Allergies: \_\_\_\_\_  Student has Asthma (increased risk factor for severe reaction)

Epi-Pen(s)<sup>®</sup> is/are located:  OFFICE     BACKPACK     ON PERSON     OTHER: \_\_\_\_\_

Inhaler(s) is/are located:  OFFICE     BACKPACK     ON PERSON     OTHER: \_\_\_\_\_

**Anaphylaxis (Severe allergic reaction)** is an excessive reaction by the body to combat a foreign substance that has been eaten, injected, inhaled or absorbed through the skin. It is an intense and life- threatening medical emergency. Do not hesitate to give Epi-pen<sup>®</sup> and call 911.

**USUAL SYMPTOMS of an allergic reaction:**

- |  |  |
|--|--|
| 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, stomach ache/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         |  |

**THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER (LHP):**

**If a student has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to something allergic to):**

1. Give     EpiPen<sup>®</sup> (0.3)     EpiPen Jr.<sup>®</sup> (0.15)  
 May repeat Epi-pen<sup>®</sup> in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived.  
Document time medications were given and alert EMS when they arrive.

_____	_____	_____	_____
Epi-pen #1	Epi-pen #2	Antihistamine	Inhaler

2. Stay with student.
3. **CALL 911** – Advise EMS that student has been given Epinephrine
4. Notify parents and school nurse.
5. After Epi-Pen<sup>®</sup> given, give Benadryl<sup>®</sup> or antihistamine \_\_\_\_\_ (dose)
6. If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction,  
 After Epi-pen<sup>®</sup> and Benadryl<sup>®</sup> may give:  
 Albuterol 2 puffs (Pro-air<sup>®</sup>, Ventolin HFA<sup>®</sup>, Proventil<sup>®</sup>)     Albuterol/ Levalbuterol unit dose SVN (per nebulizer)  
 Levalbuterol 2 puffs (Xopenex<sup>®</sup>)     Other: \_\_\_\_\_
7. **A Student given an Epi-Pen must be monitored by medical personnel or a parent & may NOT remain at school.**

**SIDE EFFECTS of medication(s):**

Epi-Pen: **increased heart rate**, \_\_\_\_\_    Benadryl: **sleepy**, \_\_\_\_\_

Albuterol/Levalbuterol: **increased heart rate, shakiness**, \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Student may carry & self administer Epi-Pen <sup>®</sup> and/or Benadryl | <input type="checkbox"/> Student has demonstrated Epi-pen administration to LHP |
| <input type="checkbox"/> Student may carry & self administer Inhaler                              | <input type="checkbox"/> Student has demonstrated inhaler use to the LHP        |

**PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY—(required by USDA Food Guidelines)**

Check here if student will eat ANY school provided meals during the entire school year. If so, the following **MUST** be completed.

Foods to omit: \_\_\_\_\_

Suggested general substitutions: \_\_\_\_\_

Check here if standard substitutions offered in your district are acceptable. (Contact district Food Services Manager for details.)

Note: Meals from home provide the safest food option at school.

LHP Signature: _____	Print Name: _____	Date: _____
Start date: _____	End date : (not to exceed current school year): _____	<input type="checkbox"/> Last day of school <input type="checkbox"/> Other: _____
Telephone #: _____	Fax #: _____	

Date plan developed/Revised: \_\_\_\_\_

Student: \_\_\_\_\_

Care Plan for Severe Allergy – Part 2—Parent Section

Brief Medical History: \_\_\_\_\_

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
Parent/guardian should be notified of any planned parties as early as possible.
Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
Student is responsible for making his/her own food decisions.
When eating student requires:
Specified eating location
No restrictions
Other:

Bus Concerns –Transportation should be alerted to student’s allergy.

- This student carries Epi-pen® on the bus?
Epi-pen® can be found in Backpack, Waist pack, On Person, Other (specify)
Student will sit at front of the bus?
Other (specify)

Field Trip Procedures – EpiPen® must accompany student during any off campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip?
Staff members on trip must be trained regarding Epi-pen® use and this health care plan (plan must be taken).
Other (specify)

EMERGENCY CONTACTS

Mother/Guardian contact information table with fields: Name, Home Phone, Work Phone, Other

Father/Guardian contact information table with fields: Name, Home Phone, Work Phone, Other

ADDITIONAL EMERGENCY CONTACTS

Table with 4 columns: ID, Relationship, Phone, and empty space for additional contact details.

My student may carry and is trained to self-administer his/her own Epi-Pen®:
My student may carry and use his/her asthma inhaler:

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e.: doctor, nurse practitioner, PAC)
I give Health Services Staff permission to communicate with the LHP/medical office staff about this medication.
I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.
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 professional.
Student is encouraged to wear a medical ID bracelet identifying the medical condition.
I request and authorize my child to carry and/or self-administer their medication.
This permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer.

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

For District Nurse’s Use Only:

Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication.
Device(s) if any, used \_\_\_\_\_ Expiration date(s): \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.