

# ANAPHYLAXIS CARE PLAN & MEDICATION ORDERS

Plan \_\_\_\_ of \_\_\_\_

Initials \_\_\_\_\_

Place student picture here

Allergy to \_\_\_\_\_

|              |           |
|--------------|-----------|
| STUDENT NAME | Birthdate |
|--------------|-----------|

|       |        |                                |                               |                                |
|-------|--------|--------------------------------|-------------------------------|--------------------------------|
| Grade | School | <input type="checkbox"/> Bus # | <input type="checkbox"/> Walk | <input type="checkbox"/> Drive |
|-------|--------|--------------------------------|-------------------------------|--------------------------------|

|   |                       |        |
|---|-----------------------|--------|
| Allergy History <input type="checkbox"/> History of anaphylaxis | Date of Last Reaction | Weight |
|---|-----------------------|--------|

|                  |   |
|------------------|---|
| Other Allergies: | <input type="checkbox"/> Student has Asthma (increased risk factor for severe reaction) |
|------------------|---|

**Brief Medical History** (including current medications)

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**Epinephrine auto-injector(s) (EAI) location**     Office     Backpack     On person     Other: \_\_\_\_\_

**Inhaler(s) location**     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 EAI and call 911.**

**USUAL SYMPTOMS of an allergic reaction. (Identify student specific symptoms)**

|   |   |
|---|---|
| <input type="checkbox"/> MOUTH--Itching, tingling, or swelling of the lips, tongue, or mouth    | <input type="checkbox"/> SKIN--Hives, itchy rash, and/or swelling about the face or extremities |
| <input type="checkbox"/> THROAT--Sense of tightness in the throat, hoarseness and hacking cough | <input type="checkbox"/> GUT--Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea   |
| <input type="checkbox"/> LUNG--Shortness of breath, repetitive coughing, and/or wheezing        | <input type="checkbox"/> HEART -- "Thready" pulse, "passing out", fainting, blueness, pale      |
| <input type="checkbox"/> GENERAL--Panic, sudden fatigue, fear of impending doom                 | <input type="checkbox"/> Other -- _____   |

**This Section to be Completed by a Licensed Healthcare Provider (LHP)**

- If student has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to allergen)
1. Administer Epinephrine auto-injector (EAI)     0.3 mg     0.15 mg (Jr)
    - May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived
  2. Call 911 – Advise EMS that Epinephrine has been administered
  3. Stay with student
  4. After EAI administered, administer \_\_\_\_\_ (antihistamine) \_\_\_\_\_ (ml/mg/cc)
  5. If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EAI, administer
 

|  |   |
|--|---|
| <input type="checkbox"/> Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) | <input type="checkbox"/> Albuterol/Levalbuterol unit dose SVN (per nebulizer) |
| <input type="checkbox"/> Levalbuterol 2 puffs (Xopenex®)                         | <input type="checkbox"/> Other _____  |
  6. Notify school nurse and parent/guardian
  7. A Student given an EAI must be monitored by medical personnel or a parent and may NOT remain at school
 

|   |  |
|---|--|
| <input type="checkbox"/> Student may carry EAI and/or antihistamine           | <input type="checkbox"/> Student has demonstrated EAI use in LHP's office  |
| <input type="checkbox"/> Student may self-administer EAI and/or antihistamine | <input type="checkbox"/> Student has demonstrated inhaler use LHP's office |
| <input type="checkbox"/> Student may carry and self-administer Inhaler        |  |
- Document time medications were administered and alert EMS when they arrive:

|        |        |               |         |
|--------|--------|---------------|---------|
| EAI #1 | EAI #2 | Antihistamine | Inhaler |
|--------|--------|---------------|---------|

|               |   |
|---------------|---|
| LHP Signature | LHP Print Name  |
| Start date    | End date <input type="checkbox"/> Last day of school <input type="checkbox"/> Other |
| Date          | Telephone   |
|               | Fax   |

## Anaphylaxis Care Plan – Part 2 – Parent/Guardian

**STUDENT NAME** \_\_\_\_\_

**Food Allergy Accommodations**

- Foods 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

Student is able to make their own food decisions  Yes  No

When eating, student requires  Specified eating location, where \_\_\_\_\_  
 No restrictions  Other \_\_\_\_\_

**Transportation staff should be alerted to student's allergy**

- Student carries Epinephrine auto-injector (EAI) on the bus/transportation  Yes  No
- EAI can be found  On person  Other (specify) \_\_\_\_\_
- Student will sit at front of the bus  Yes  No
- Other (specify) \_\_\_\_\_

**Field Trip/Extracurricular Activity: EAI must accompany student during any off campus activity**

- The student must remain with the teacher or parent/guardian during the entire field trip  Yes  No
- Field trip staff must be trained to medication and health care plan (health care plan must also accompany student)

**Other Accommodations** \_\_\_\_\_

- Does student need other classroom, school activity, or recess accommodations  Yes  No

**EMERGENCY CONTACTS**

|   |           |  |                          |        |  |
|---|-----------|--|--------------------------|--------|--|
| <b>Parent/Guardian</b>  | Name      | <b>Parent/Guardian</b>                                   | Name                     |        |  |
|   | Primary # |  | Primary #                |        |  |
|   | Other #   |  | Other #                  |        |  |
|   | Other #   |  | Other #                  |        |  |
| Name:   |           | Relationship:  |                          | Phone: |  |
| My child may carry and is trained to self-administer their EAI            |           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Provide extra for office |        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| My child may carry and is trained to self-administer their rescue inhaler |           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Provide extra for office |        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| My child may carry their EAI (needs assistance to administer)             |           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |        |  |

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care plan, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- Medical information may be shared with school staff working with my child and EMS, if they are called.
- I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatment in accordance with the licensed healthcare provider's (LHP) instructions.
- This is a life-threatening care plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's severe allergy between the LHP office and the school nurse.

**I have reviewed and agree with this health care plan/504 and medication/treatment order.**

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

**For School District Nurse Only**

A Registered Nurse has completed a nursing assessment and developed this Anaphylaxis Care Plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication ordered above:  Yes  No If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered:  Yes  No

Device(s) if any, used \_\_\_\_\_ Expiration date(s) \_\_\_\_\_

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**Registered 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.