Severe Allergy Medical Care Plan

\*This care plan is valid for **one school calendar year** and must be update by the prescribing physician if any changes are made during the school year\*

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School/Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGY**: (Check appropriate box and list specific allergen)

☐ Foods: ☐ Peanut ☐ Tree Nut Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Latex

☐ Stinging Insects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Asthma: ☐ Yes ☐ No

If your child needs medication at school for asthma, please complete a **separate** Asthma Care Plan.

**Contact Information**

**First Contact Second Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (2): \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ YES ☐ NO I would like to talk with the school nurse regarding my child’s allergies.

☐ YES ☐ NO My child is to self-carry their own medication. (A self carry form **must** be signed to self-carry)

☐ YES ☐ NO If my child is to self-carry epinephrine, I will still supply the school with a back up auto-injector.

Page one of this care plan is to be completed, signed and dated by a parent/guardian.

Page two of this care plan is to be completed, signed and dated by the treating physician or licensed prescriber.

Without **both** signatures this care plan is not valid. The parent/guardian is responsible for supplying none expired medication.

I certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of medications at school. I agree to have the information within this medical care plan shared with staff, as needed. I give permission for Holly Area Schools (HAS) staff to give the medication(s) as ordered on this care plan for allergic reactions. I give my permission for staff to contact the physician/licensed prescriber for clarification of these orders, if needed. I will not hold HAS Board of Education or its personnel, or employees responsible for complications related to the medication or treatment/care administered pursuant to this plan.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature Date**

*Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.*

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ School Year: \_\_\_\_\_\_\_\_\_\_\_\_**

**Mild Symptoms Monitoring**

* Give Antihistamine-If prescribed (see below) Stay with Student & remain calm
* Call parent/guardian & district nurse Provide reassurance
* If Symptoms progress: **USE EPINEPHRINE** (see below) Monitor for worsening symptoms

**Any SEVERE SYMPTOMS after suspected or known ingestion: Inject Epinephrine Immediately!**

**Call 911**, then parent/guardian & nurse

**One or more of the following (any combination):** Give additional medication\* (if ordered)

**Lung:** Short of breath, wheezing, repetitive cough (Antihistamine or inhaler)

**Heart:** Pale, faint/weak pulse, dizzy, confused Tell rescue staff that epinephrine was given

**Throat:** Tight, hoarse, trouble breathing/swallowing & time administered. What the suspected

**Mouth:** Tongue or lips swelling, blue around lips, metal taste allergen was. (**If** having trouble breathing-

**Skin:** Multiple hives on body, itchy, swelling of an area or face allow student to sit up). Have student

**Gut:** Vomiting, cramping like pain, diarrhea lay down with feet elevated. Roll to side

**Mental:** Anxiety, confusion, sense of impending doom if vomiting. Treat student even if parents  cannot be reached.

\***2nd dose** may be given if symptoms

\* If a student is to self-carry epinephrine, help may still be worsen and help has not arrived.

needed to give the medication. **Start CPR, if necessary.**

**Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan**

☐ If checked, give epinephrine **immediately** if **ANY** symptoms are present, if allergen was **likely** eaten.

☐ If checked, give epinephrine **immediately,** if the allergen was **definitely** eaten, even if **no** symptoms are noted.

**Epinephrine IM (intramuscular) dose:** ☐ .15 (junior) ☐ .3 (adult)

Authorization for **student to self carry: ☐ Yes ☐ No** - The student has been instructed on how to use the epinephrine injector correctly, knows when to get assistance and not to share their medication. Therefore it is my professional opinion the student should be allowed to self-carry their own epinephrine.

**Antihistamine** **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dosage:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Route:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Should antihistamine be administered before Epinephrine, if mild symptoms present? ☐ Yes ☐ No**

**Please list parameters for antihistamine use:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Route: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list parameters for usage of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other instructions or orders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician/Licensed Prescriber Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**