

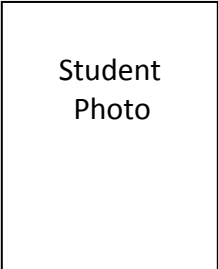
# ALLERGY/ANAPHYLAXIS CARE PLAN

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Teacher \_\_\_\_\_

School Nurse \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Healthcare Provider \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

HISTORY OF ASTHMA:  No  Yes-*Higher risk for severe reaction*



ALLERGY: (check appropriate) *To be completed by Healthcare Provider*

- Foods (list):
- Medications (list):
- Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)
- Stinging Insects (list):
- Other (list):

**RECOGNITION & TREATMENT:**

Chart to be completed by Healthcare Provider ONLY		Give CHECKED Medication	
<i>If food ingested or contact w/ allergen occurs:</i>		Epinephrine	Antihistamine
No symptoms noted	<input type="checkbox"/> Observe for other 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+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
<i>If reaction is progressing (several of the above areas affected), GIVE:</i>			
<b><i>The severity of symptoms can quickly change. + = Potentially life-threatening.</i></b>			

**DOSAGE:**

- ✓ **Epinephrine:** Inject into outer thigh (through clothing)  0.3 mg OR  0.15 mg
- ✓ **Antihistamine:** Liquid Diphenhydramine (Benadryl®) \_\_\_\_\_mg. *To be given by mouth only if able to swallow.*  
OR Benadryl fastmelts \_\_\_\_\_ mg. (depends on which is available)*To be given by mouth only if able to swallow*

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

- 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.
- It is my professional opinion (HCP) that this student **SHOULD NOT** carry an auto-injector.
- This child has special needs and the following instructions apply: \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Phone: \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY PROTOCOL:**

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

1. Call parents/guardian to notify of reaction, treatment and student's health status.
2. Treat for shock. Prepare to do CPR.

# ALLERGY/ANAPHYLAXIS CARE PLAN

**Side 2: To Be Completed by Parent/Guardian, Student and School**  
**Allergy/Anaphylaxis Action Plan (continued)      Student Name \_\_\_\_\_**

**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.**

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: \_\_\_\_\_ Date \_\_\_\_\_

Approved by Nurse/Principal Signature: \_\_\_\_\_ Date \_\_\_\_\_

**PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis.**

Critical components to prevent life threatening reactions:  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 of building
	Encourage a no-peanut zone in the school cafeteria
	Other:

**STAFF MEMBERS TRAINED**

Name	Title	Location/Room #	Trained By(RN only)