Anchorage School District

Allergy/Anaphylaxis Care Plan

Student:	DOB:	Grade:	Student ID:

Hx of Condition

Oral Allergy Trigger(s)	KNOWN:
	SUSPECTED:
Anaphylaxis Trigger(s)	KNOWN:
	SUSPECTED:
Hx of Asthma *(increases the risk of having a more severe reaction)*: ☐ Yes ☐ No	
Student can self-carry and administer EpiPen: ☐ Yes ☐ No	

Medical Provider Orders

Symptoms	**Treatment** **Guidelines adopted from AAFA Allergy/Anaphylaxis Plan*
Oral Allergy Syndrome	**Give these medications**
Student has *any* of these mild symptoms ▪ **Mouth:** mild itchiness, tingling, or swelling of lips/tongue ▪ **Skin:** mild hives, itchy rash, or swelling of face	☐ Any available PO antihistamine per package instructions. ☐ Other: *Monitor for 30 minutes. If student develops a second symptom, or symptoms worsen, or do not improve move to Red Zone and contact parent/guardian.*
Red Zone	**Give these medications and CALL 911**
Student has *any* of these symptoms ▪ **Mouth:** swelling of lips/tongue ▪ **Throat:** tightening, hoarseness ▪ **Skin:** swelling of face, cyanotic, pale ▪ **Gut:** nausea, vomiting, diarrhea, cramps ▪ **Lungs:** dyspnea, repetitive coughing, wheezing ▪ **Heart:** thready pulse, low BP, faint ▪ **Neuro:** altered mental status, dizzy, unconscious ▪ **Student Specific:**	☐ EpiPen 0.15 mg IM may repeat Q5min if symptoms persist or resolve and then return. ☐ EpiPen 0.30 mg IM may repeat Q5min if symptoms persist or resolve and then return. ☐ Any available PO antihistamine per package instructions for persistent skin, nasal, or ocular symptoms following epinephrine. ☐ Other:
Additional Orders/Notes	

Medical Provider:	NPI:	Phone:
Signature:	Email:	Date:

Anchorage School District

Allergy/Anaphylaxis Care Plan

Student:	DOB:	Grade:	Student ID:

Parent/Guardian Authorization

I request that the medication(s) and allergy/anaphylaxis protocols listed on this plan be provided to my child. I will provide needed medications or supplies for care in school. I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication. I agree to defend and hold school district employees harmless from any liability for the results of the care, or the way it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I agree for the nurse to share health information with school staff on a need-to-know basis for my child's safety and to foster academic success. I understand that this medication(s) will be disposed of at the end of the school year unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

Name:	Phone:
Signature:	Date:

This authorization expires at the end of the current school year.

Student Self-Carry Agreement

It is indicated within the Medical Provider Orders of this Allergy/Anaphylaxis Care Plan that I may self-carry medications. I have been trained in the use of my emergency medication. I understand the signs and symptoms of an allergic reaction and agree to always have my medication available. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if my medication does not help with my symptoms. I will not share my medication with other students or leave my medication unattended. I will use my medication only for the prescribed purpose.

Name:	Student ID:
Signature:	Date:

Nurse Delegation for UAP *(initialed and signed by delegating nurse)*

☐ _____ *I **AUTHORIZE** the delegation of the medication(s) and nursing duties within this Care Plan to the "Full UAP" as indicated on the UAP Training Log in accordance with 12 AAC 44.965 and the BON Advisory Opinion NUR_AdOp_Medication. I acknowledge that I have assessed the student and have trained the UAP in utilizing the rescue medications in the event of an emergency. The UAP has been referred to the Drug Facts on the medication packaging for written instructions on storage, administration, dosing, measurement, and timing requirements; expected outcome (Purpose); contraindications (Do Not Use); interactions of medications (Ask a doctor…); unexpected outcomes (Stop use…) and what to do in the event of one; and will contact the nurse (or Healthcare Services when the nurse is unavailable) in the event symptoms worsen or do not improve, or in the event of an unexpected outcome.*

☐ _____ *I **DO NOT AUTHORIZE** the delegation of the medication(s) and nursing duties within this Care Plan.*

Nurse:	Initials:
Signature:	Date: