Individual / Emergency Care Plan for Allergic Reaction

Student's Name: ______________________________ D.O.B: _________________ Grade: _____________

ALLERGY TO: ____

Asthmatic: Yes ( )* No ( ) *Higher risk for severe reaction

Previous Episode of Anaphylaxis Yes ( ) No ( ) If yes, when? ________________

Type of Past Reaction: ______________________________ Date Epi-Pen Last Administered: __________

TREATMENT – to be filled out by Healthcare Professional

(If the student is experiencing the following symptoms, administer the appropriate medication.)

Symptoms		**Give Checked Medications**
	( ) Epi-Pen	( ) Antihistamine
Mouth- Itching, tingling, or swelling of lips, tongue, mouth	( ) Epi-Pen	( ) Antihistamine
Skin- Hives, itchy, rash, swelling on face or extremities	( ) Epi-Pen	( ) Antihistamine
GI- Nausea, abdominal cramps, vomiting, diarrhea	( ) Epi-Pen	( ) Antihistamine
General- Panic, sudden fatigue, chills, fear of impending doom	( ) Epi-Pen	( ) Antihistamine
Throat*- Tightening of throat, hoarseness, hacking cough	( ) Epi-Pen	( ) Antihistamine
Lung*- Shortness of breath, repetitive coughing, wheezing	( ) Epi-Pen	( ) Antihistamine
Heart*- Thready pulse, passing out, fainting, pale, blueness	( ) Epi-Pen	( ) Antihistamine
Other*- ____	( ) Epi-Pen	( ) Antihistamine
If food allergen has been ingested, but no symptoms	( ) Epi-Pen	( ) Antihistamine

* Potentially life-threatening.

MEDICATION ORDERS-

Epi-Pen 0.3 mg ( ) / Epi-Pen Jr. 0.15mg ( ) **Side Effects:______________________________**

If YES, when:____

Antihistamine: ( ) _________ cc/mg **Give: ______Teaspoons ______ Tablets p.o.**

Side Effects: ______________________________

- **Student to carry Epi-Pen during school hours** **Yes ( ) No ( )**
- **Student may self-administer Epi-Pen** **Yes ( ) No ( )**
- **Student has demonstrated use to LHCP Yes ( ) No ( ) School Nurse Yes ( ) No ( )**

- It is my professional opinion that this child should be provided with a section of a table where efforts are made to exclude the allergen ___________________. Yes ( ) No ( )
- Additional school environment measures needed:____

Prescriber's Signature: _____________________________________ Date: __________________________

Printed Name: ____

Individual Considerations:

- Bus-Transportation should be alerted to Student's allergy by the Parent.
- This student carries Epi-Pen on the Bus: Yes ( ) No ( )
- Epi-pen can be found in: Backpack ( ) Waist pack ( ) On Person ( ) Other ( )
- Student will sit at front of the bus: Yes ( ) No ( )
- Other (specify): ____

Field Trip:

In event of field trip…………..

___* As noted by the prescriber my child may self-administer, if the child has demonstrated competency.
(Prescriber must have indicated "YES".)

___ I or my designee will be able to attend my child's field trips and assume responsibility for my child's medical and medication needs.

___ I give permission for a responsible adult trained by the school nurse to give my child this medication. (Under Mass. General Law regulating Delegation of Medication in the school setting.)

Classroom Management: by physician order

- ( ) Middle School / High School student will be making his/her own decision.
- ( ) Classroom projects will be reviewed with Parent by Teacher before assigned.

NOTE: Classroom teachers will use food manipulative in the classroom as little as possible.

ACTION PLAN

- **GIVE MEDICATION** as ordered. AN ADULT WILL **STAY WITH STUDENT** AT ALL TIMES. (wait for EMS)
  -- **NOTE TIME**_________Epi-Pen given. **NOTE TIME** _________Antihistamine given.
- **CALL 911 IMMEDIATELY.** 911 must be called **WHENEVER** Epi-pen is administered**.**
- **DO NOT HESITATE to administer Epi-pen and to call 911 even when a Parent can not be reached.**
- Advise 911 a student is having a severe allergic reaction and Epi-Pen is being administered.
- Call the School Nurse or School Administrator.
- Notify the Parent
- Dispose of used Epi-Pen by giving it to EMS along with a copy of the Health Care Plan.

Contact Parents / Guardians:

Parent / Guardian: Name: ______________________________ Telephone #:_____________________________
Parent / Guardian: Name: ______________________________ Telephone #:_____________________________
Emergency Contact: Name: ______________________________ Telephone #:_____________________________

Please note: *All Medications must be in their original and/or pharmacy labeled containers and delivered to the Nurse by a responsible Adult. They may be retrieved by the parent/guardian at any time. Medications will be disposed of if they are not picked up within one week following the completion of the last day of school.*

Parent's/Guardian's Signature: ____ Date: ___________

For Health Office Use Only

Student has demonstrated competency in Epi-Pen /allergy medication administration. YES ( ) NO ( )

Medication storage location: ___________________________________ Date EXPIRES: ________________