STUDENT ALLERGY/ANAPHYLAXIS CARE PLAN

Student Photo

Student Name _____ D.O.B. _____ Teacher _____
School Nurse_____ Phone Number _____
Health Care Provider _____ Preferred Hospital _____
History of Asthma ☐ No ☐ Yes (Higher risk for severe reaction)

ALLERGY: (check appropriate) **TO BE COMPLETED BY HEALTH CARE PROVIDER *ONLY***

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

RECOGNITION AND TREATMENT: **To be completed by Health Care Provider *ONLY***		**Give CHECKED Medication**	
If food ingested or contact with allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	☐ 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		
If reaction is progressing (several of the above areas affected), **GIVE:**			
The severity of symptoms can quickly change. + Potentially life-threatening			

DOSAGE:* TO BE COMPLETED BY HEALTH CARE PROVIDER *ONLY

- **Epinephrine:** Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
- **Antihistamine: Diphenhydramine (Benadryl®)** _____ mg (Liquid or Fastmelts). 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 that this student **SHOULD NOT** carry the auto-injector.
☐ This child has special needs and the following instructions apply: _____

_____.

Health Care Provider Signature _____ Phone: _____ Date _____

ASD EMERGENCY PROTOCOL:

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.

Rev 7/09
Form adapted from the Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, Alaska Chapter

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Care Plan (continued) Student Name _____ D.O.B. _____

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. My signature below provides authorization for this contact. I also understand that a signature is mandatory for school acceptance of this form.

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, 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(s) of building
	Encourage a no-peanut zone in the school cafeteria
	Other:

STAFF MEMBERS TRAINED:

NAME	TITLE	LOCATION/ROOM	TRAINED BY (RN only)

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