SEVERE /LIFE THREATENING ALLERGY PLAN/MEDICATION ORDERS

Student's Full Legal Name: _____ DOB: _____ Grade: ___

Parent/Legal Guardian's Printed Name: _____

Phone: (H) _____(W) _____ (C) _____

Second Contact Person: _____ Phone: _____

SEVERE ALLERGY TO: _____ (Allergen) ASTHMATIC: __Yes __No

SIGNS OF AN ALLERGIC REACTION	
Throat*	itching and/or sense of tightness in the throat, hoarseness, and hacking cough
Lung*	shortness of breath, repetitive coughing and/or sneezing
Heart*	"thready" pulse, fainting and/or feeling may "pass out"
Mouth	itching and swelling of the lips, tongue or mouth
Skin	hives, itchy rash and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting and/or diarrhea
The severity of symptoms can quickly change. *Symptoms in any of the top three systems can be immediately life-threatening . IN THE PRESENCE OF **ANY** OF THE ABOVE SYMPTOMS a child with severe allergies should be observed continuously.	

	ACTION
1.	If exposure to allergen is suspected, or if the child exhibits ANY symptoms, give epinephrine (inject into thigh and hold for 10 seconds OR, per manufacturers/HCP direction)
2.	**CALL 911**
3.	Call Parent/Legal Guardian
4.	Call School Nurse

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911

Registered nurses cannot delegate assessment and clinical judgment to unlicensed school staff, therefore, Benadryl or Antihistamine will not be given first and there cannot be a "wait and watch" period of time. Epinephrine will be administered as ordered.

MEDICATION ORDERS: To be completed and signed by Licensed Health Professional	
1.	Give epinephrine _____Jr. 0.15 mg _____0.3 mg
2.	After Epinephrine, give Antihistamine _____ (ml/mg/cc) every _____.
3.	If child has a history of Asthma and is: wheezing, having chest tightness, or shortness of breath with allergic reaction AFTER Epinephrine is administered: Rescue Inhaler as authorized.
Please list side effects of medications:	
Epinephrine:	
Antihistamine:	
Emergency Procedure in Case of Side Effects:	
Duration of Order: Current School Year _____	
Child was instructed and demonstrated use? ___Yes ___No May Self-carry / Self-administer: ___Yes___No	
Licensed Health Professional's Signature: _____ Date: _____	
Licensed Health Professional's Printed Name: _____	
Address: _____	

SEVERE /LIFE THREATENING ALLERGY PLAN/MEDICATION ORDERS

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN		
Student's Full Legal Name:	DOB:	Grade:
Allergy History: History of anaphylaxis/severe reaction: _____Yes _____No		
Allergy indicated by testing: _____Yes _____No	Date of Last Reaction: _____	
Other Allergies:		
Child has Asthma: _____Yes _____No		
Student: Rides Bus #_____ Walks_____ Picked Up _____ Drives_____ Other_____		

FOOD ALLERGY ACCOMMODATIONS:
Child is responsible for making their own food decisions: _____Yes _____No
-Parent/Legal Guardian should be notified of any planned parties as early as possible
-Classroom projects should be reviewed by teaching staff to avoid specific allergen(s)
-Foods and alternative snacks will be provided by parent/legal guardian _____Yes _____No
-When eating, child requires: ____Specific eating location Where? _____

I certify that I am the parent/legal guardian or other person in legal control of the above identified child. My signature indicates my involvement and agreement with the information and plan as stated above. I request that this medication be given as ordered by the licensed health care provider. I give permission for Health Services Staff to communicate about this condition with Licensed Health Care Provider's office, 911 responders/and school staff working with my child. All medication supplied must be unexpired and come in its original container provided with instructions as noted above by the licensed health care provider. Any permission to possess and self-administer medication may be revoked by the principal or school nurse if it is deemed that your child is not safely and effectively able to carry or self-administer.

I request and authorize my child to carry and/or self-administer their medication: ___Yes ___ No

I will supply backup epinephrine for health room. _____Yes _____No

Parent/Legal Guardian's Signature: _____ Date: _____

FOR LICENSED NURSE USE ONLY

This child has demonstrated to the licensed nurse, the skill to use the medication and any device necessary to administer the medication ordered whether self-administered or not. _____Yes _____No
This plan has been reviewed /approved by the registered nurse.

Licensed Practical Nurse's Signature (if applicable): _____ Date: _____

Registered Nurse's Signature: _____ Date: _____

A signed copy of this plan will be kept in the Health Room. Recommendation sent to the school administration to self-carry per District Policy #3419.

	Epi-pen:	**Inhaler:**
In health room?	__Yes __No	___Yes __No
Expiration date:	_____	
Carries in:	___Backpack ___ Purse ___Other	