

**IMMACULATE CONCEPTION SCHOOL
ALLERGY- EMERGENCY HEALTH CARE PLAN FOR YEAR 20__ TO 20__**

Student's Name: _____ DOB _____ Grade/Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* ___ No ___ Previous episode of anaphylaxis Yes* ___ No ___

*higher risk for severe reaction

Location of epinephrine (check all that apply) _____ with nurse _____ with student _____ other _____

SECTION 1 TREATMENT-to be completed by the physician/advanced practice nurse

Symptoms

Give Checked Medication

If allergen has been ingested or student stung by an insect To be determined by physician
but no symptoms----- ()Epinephrine()Antihistamine

Mouth Itching, tingling, or swelling of lips, tongue, mouth--- ()Epinephrine()Antihistamine

Skin Hives, itchy rash, swelling on face or extremities----- ()Epinephrine()Antihistamine

Gut Nausea, abdominal cramps, vomiting, diarrhea----- ()Epinephrine()Antihistamine

General Panic, sudden fatigue, chills, fear of impending doom ()Epinephrine()Antihistamine

Throat * Tightening of throat, hoarseness, hacking cough ----- ()Epinephrine()Antihistamine

Lung * Shortness of breath, repetitive coughing, wheezing---- ()Epinephrine()Antihistamine

Heart * Thready pulse, passing out, fainting, pale, blueness---- ()Epinephrine()Antihistamine

Other* _____ --- ()Epinephrine()Antihistamine

If reaction is progressing (several of the above affected)*----- ()Epinephrine()Antihistamine

* Potentially life threatening----severity of symptoms can change rapidly

DOSAGE

**Epinephrine : Inject intramuscularly (circle one) Epipen 0.3mg Epipen Jr. (0.15 mg)
Twinject (0.3mg) Twinject (0.15mg)**

Epinephrine may be repeated in _____ minutes.

Antihistamine: give _____
medication/dose/route

Other: give: _____
Medication/dose/route

**CALL 911 state “a student has had a severe allergic reaction, epinephrine may be needed. Send paramedics”
Student must be transported to the nearest hospital. Then call parents/emergency contact.
EVEN IF PARENTS CANNOT BE REACHED DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED TO HOSPITAL.**

TREATMENT BY A DELEGATE WHEN A NURSE IS NOT PRESENT(Please check one answer):

P.L.2007,c 57 directs that the school nurse shall designate additional employees who volunteer to administer epinephrine to a student who has anaphylaxis when a nurse is not physically present at the scene.

_____ **Delegate Order- For suspected exposure to allergen(s) listed above,** delegates are to administer prescribed auto-inject epinephrine. (Note delegates may NOT administer an antihistamine as the first treatment.)

_____ **This student's order should not be delegated.**

TREATMENT BY STUDENT (SELF ADMINISTRATION) (Please check all that apply):

P.L. 2007, c 57 directs that a student may be permitted to self administer medications for potentially life threatening illness provided proper procedures are followed.

_____ This student has a potentially life threatening allergy and will carry epinephrine at all times in school or when attending a school sponsored event.

_____ This student understands, has been instructed, and is capable of the proper technique of self administration of the prescribed medication(s).

_____ This student is aware that he /she must report any suspected exposure to allergen, any signs of allergic reaction, and any use of prescribed medication to an adult immediately.

_____ This student is **unable to self administer medications.**

Physician's Signature: _____ Date: _____ Phone: _____

SECTION 2 (To be completed by parent/guardian)

_____ I verify that my child _____ a student at Immaculate Conception School/Clinton, has a potentially life threatening allergy that could result in anaphylaxis. He/she **has been instructed in self administration** of the prescribed medication in the event of a life threatening situation and has my permission to carry and self administer the medication prescribed.

_____ I verify that my child _____ a student at Immaculate Conception School/Clinton has a potentially life threatening allergy that could result in anaphylaxis. He/she is **unable to self-administer** the prescribed in the event of a life threatening situation. I hereby request the school nurse or delegate to administer the prescribed medication to my child.

In order to keep my child safe at school or a school sponsored event, I consent to the following for the 20____-20____ school year.

- I will provide the medication(s) prescribed in its original prescription container.
- I will remind my child to have the medication with them at all times (if ordered).
- Antihistamine prescribed to be kept with the student will be a single pre-measured dose, in its original labeled container.
- Extra medication will be kept in the Health Office and/or my child’s classroom as applicable.
- I authorize the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications.
- I authorize the school nurse to share this medical information with members of the ICS staff who may have responsibility for my child in school or at a school sponsored event.
- _____ I give my permission to include my child on the list of special health needs children.
- _____ I give my permission to include my child’s photograph on the picture list of children with allergies.
- _____ I **do not** want my child’s photograph on the picture list of children with allergies.
- _____ I **do not** authorize the release of medical information to members of the ICS staff .
- I will contact the school nurse with any questions or changes in my child’s health condition.

EMERGENCY CONTACTS

_____ Mother (h): _____ (cell): _____ (work): _____

_____ Father (h): _____ (cell): _____ (work): _____

Other Name/Relationship: _____ phone: _____ cell: _____

_____ phone: _____ cell: _____

Dr. _____ phone: _____

TRAINED STAFF MEMBERS

1. _____ Room: _____ phone: _____

2. _____ Room: _____ phone: _____

3. _____ Room: _____ phone: _____

Parent/Guardian signature _____ Date: _____