Place Child's Picture Here

Prevention Plan

Student's Name:		Date of Birth:	
Teacher's Name:		Room #:	
ALLERGY TO:			
Asthmatic? (Y/N)		(Yes=Higher Risk for Severe Reaction)	

School will:

- ☐ A Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to:_____
- ☐ Have staff trained on individual emergency plans
- ☐ School staff will make every reasonable effort to prevent the student's exposure to known allergens
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans
  → for student medication and specific actions plans for emergency care
- ☐ Current, non-expired medications
- ☐ Provide safe snack option to school/classroom
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Make every effort to avoid contact with allergen
- ☐ Alert nearest adult if suspect exposure to allergen
- ☐ Other

Notes:

Place Child's Picture Here

Management of Severe Allergic Reactions & Anaphylaxis

Student's Name: _____ **Date of Birth:** _____
Teacher's Name: _____ **Room #:** _____
ALLERGY TO: _____

_____

Asthmatic? (Y/N) _____ (Yes=Higher Risk for Severe Reaction)

STEP 1: TREATMENT

Symptoms	**Give This Medication**	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but *no 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*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected):		

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly:

EpiPen® or generic _____ EpiPen JR® or generic _____ Auvi-Q _____

Antihistamine: give _____

Other: give _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

_____ _____
Doctor's Name **Doctor's Phone Number**

_____ _____
Parent's Name **Parent's Phone Number**

_____ _____
Emergency Contact 1 Name/Relationship **Emergency Contact 1 Phone Number**

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

_____ _____
Parent Guardian's Signature/Date **Doctor's Signature/Date**

Medication Form/Physician's Order (To be Completed by the Physician/Authorized Health Care Provider)

School: _____ Grade: ____ Date of Order: _____ Order Expires End of School Year or (date): _____

Student Name: _____ Order valid for current year/Summer (check if appropriate) ☐

DOB: _____ Gender: M F Allergies: _____

Name of Medication: _____ Dose: _____ Route: _____ Time to Give Medication: _____

Reason for Medication: _____ Frequency of Medication (IF PRN):_____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

Parent/Guardian Name:	**Physician Name:**	**Phone:**
Phone:	**Address:**	
PARENT SIGNATURE:	**PRESCRIBER SIGNATURE:**	

Medication Administration Record (For School/Camp Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
June																															
July																															

Name/Position Initials Name/Position Initials

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

RN Signature: _____ **Date:** _____

CODES: Chart Reason (see H.S. Manual)

X: School Closed FT: Field Trip

A: Absent: R: Refused

N: None Available O: Omitted

NS: No Show to HR H: Dose Held

D/C: Med. Discontinued

L/E: Late Arrival/Early Dismissal

Medication Administered (This side for school use only)

Student Name:

Date	Time	Student Complaint	R.N. Consulted ✓	Medication Administered as Ordered ✓	Student Outcome	Staff Initials	Parent Notified ✓

Comments: