

MSAD#1 Emergency Health Care Plan: School Year: _____ to _____
Allergy and Anaphylaxis Emergency Plan

STUDENT: _____ DOB: _____ GRADE: _____ WT: _____

ALLERGY TO: _____

- Child has asthma. Yes No (If yes, higher chance of severe reaction)
Child has had anaphylaxis. Yes No
Child may carry medicine. Yes No (If no, epinephrine will be kept in school's office)
Child may give him/herself epinephrine. Yes No (If child refuses/is unable to self-treat, an adult must give the epinephrine.)

**ANAPHYLAXIS IS A POTENTIALLY LIFE-THREATENING, SEVERE ALLERGIC REACTION.
IF IN DOUBT, GIVE EPINEPHRINE.**

SIGNS OF A SEVERE ALLERGIC REACTION MAY INCLUDE ANY OF THE FOLLOWING. IF A CHILD HAS ANY OF THESE SEVERE SYMPTOMS AFTER EXPOSURE TO A KNOWN ALLERGEN, GIVE EPINEPHRINE:

- Trouble breathing or swallowing
- Shortness of breath, wheezing, coughing
- Sense of tightness and/or itching in the throat, hoarseness, hacking cough
- Itching & swelling of the lips, tongue or mouth that bother breathing.
- Hives, itchy rash, and/or swelling about the face or extremities, redness over body
- Vomiting and/or diarrhea (if severe or combined with other symptoms)
- Weak pulse, fainting or dizziness
- Skin color is pale or has a bluish color
- Feeling of 'doom', confusion, altered consciousness or agitation

IF KNOWN OR SUSPECTED EXPOSURE TO ALLERGEN, OR ABOVE SYMPTOMS ARE PRESENT:

- ADMINISTER ADULT EPI-PEN (0.3MG: IF OVER 60 LBS) **OR**
- ADMINISTER EPI-PEN, JR. (0.15MG)
- **CALL 911**

AFTER GIVING EPINEPHRINE:

- GIVE OTHER MEDICATION IF PRESCRIBED:
 - BENADRYL/ANTIHISTAMINE (BY MOUTH): Dose: _____
(Antihistamine is **not** to be used in place of epinephrine)
 - INHALER _____
- **BE SURE CALL 911 HAS BEEN CALLED**
- CALL SCHOOL NURSES: 764-8105
- CALL PARENTS/GUARDIANS or EMERGENCY CONTACT as listed on back

IN AN EMERGENCY, IF UNABLE TO REACH PARENTS/GUARDIANS, DO NOT HESITATE TO ADMINISTER MEDICATION AND TRANSPORT THE STUDENT TO THE NEAREST HOSPITAL BY AMBULANCE FOR EMERGENCY MEDICAL CARE.

- My child no longer needs to have an **epi-pen** at school at this time. Should the need arise, I will contact the school nurse, bring in the medication and complete the appropriate paperwork at that time.

I am aware that if the school nurse is not present at the time of need and my child is not trained to self-administer epinephrine, a designated-trained non-medical school employee may administer the epinephrine.

PARENT SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

***Adapted using the American Academy of Pediatrics: Allergy & Anaphylaxis Emergency Plan as presented in the Allergy & Asthma Today Journal, Volume 15, Issue1, Spring/Summer 2017**

Student Name: _____

For Parents and School Nurses

Nursing Diagnosis: Potential for respiratory distress due to anaphylactic reaction to allergen.

Medications taken at home: _____

Medications taken at school: _____

The School will:

- School Nurses will assess and treat student following the Emergency Health Care Plan
- Teachers will follow the Emergency Health Care Plan
- Teachers and appropriate staff will be trained in use of epinephrine
- Teachers will inform parents of upcoming parties, field trips and after school activities
- Inform Food Services Director, Bus Driver and other staff, as appropriate, of student's allergies.

The Parents will:

- Keep school nurses informed of any changes to allergies or to care
- Provide unexpired epinephrine to school at all times
- Provide special snacks, to be kept at school, for unplanned celebrations
- Plan for field trips, parties and after school activities with teacher

The Student will:

- Care for self by avoiding known allergens
- Inform teacher if not feeling well
- If carrying own epinephrine, student will care for and handle this medication appropriately

Medical Provider: _____

Bus number: _____ Bus Garage Secretary and Bus Driver informed of allergy: _____

Parent Contact Numbers:

Mom (name): _____ Home: _____ Cell Phone: _____ Work: _____

Dad (name): _____ Home: _____ Cell Phone: _____ Work: _____

Emergency Contact Number:

Name: _____ Home: _____ Cell Phone: _____ Work: _____

Name: _____ Home: _____ Cell Phone: _____ Work: _____

Name: _____ Home: _____ Cell Phone: _____ Work: _____

Name: _____ Home: _____ Cell Phone: _____ Work: _____

In order to provide the best care possible in the school setting, authorized staff has access to Power School (our school based confidential computer software). Your child's medical diagnosis will be stated in the Medical Alert section of Power School and will be shared with their teacher via e-mail.

I give my permission for the school nurse to exchange information with the appropriate MSAD#1 faculty, staff and medical providers regarding medications and emergency care.

I am aware that if the school nurse is not present at the time of need, a designated, trained, medically- unlicensed, school employee may administer the needed care.

I also request that a hard copy of this care plan be presented to the ambulance crew in the event that their response to emergency situation is necessary.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

The following is to be completed by the School Nurse per parent and provider request:

- The proper use of prescribed epi-pen has been reviewed with student. The student demonstrates competency in the use of the prescribed epi-en per MSAD#1 Student Epi-pen Injection Management Skills Competency Assessment Guidelines.
- Does not self-administer.

School Nurse Signature: _____ Date: _____