

ANTI-HISTAMINE 1st-- EAI CARE PLAN & MEDICATION ORDERS/504

ALLERGY (No History of Anaphylaxis)

Place student picture here

Plan: _____ / _____ Date plan created: _____ Date plan revised: _____ Weight: _____ Height: _____	
NAME: _____	Birthdate: _____ PE/Sport: _____
Grade: _____ School: _____	☐ Bus # ☐ Walk ☐ Drive
Doctor: _____ Phone: _____	Fax: _____ Preferred Hospital: _____
History (including current medication): _____	

Antihistamine location ☐ Office ☐ Backpack ☐ On person ☐ Other: _____

Epinephrine auto-injector(s) (EAI) location ☐ Office ☐ Backpack ☐ On person ☐ Other: _____

Licensed Health Professional (LHP) Orders / Care Plan for Allergy

If you suspect an exposure to _____ (allergen/s), treat the reaction as follows:

1. Medication Doses

Antihistamine _____ cc/mg	Give: _____ Teaspoons _____ Tablets, by Mouth Repeat Dose: _____ (when) Side Effects: _____
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2. CALL SCHOOL NURSE AND PARENT/GUARDIAN

3. IT MAY BE NECESSARY FOR PARENT/GUARDIAN TO TAKE STUDENT HOME.

SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY.

Some Symptoms can be life-threatening! ACT FAST!

****SEE BELOW IF SYMPTOMS PROGRESSES****

STUDENT HAS EPINEPHRINE AUTO-INJECTOR AVAILABLE

ANAPHYLAXIS IS HIGHLY LIKELY WHEN THE FOLLOWING CRITERIA ARE FULFILLED:

Onset of an illness (minutes to several hours), with involvement of the skin, after exposure to a likely allergen for that student: (eg. Generalized hives, itching, or flushing):

AND/OR AT LEAST ONE OR MORE OF THE FOLLOWING:

- Respiratory compromise (e.g. shortness of breath, wheeze, blue around lips & nail beds)
- Reduced blood pressure (e.g. weakness [collapse], dizziness, incontinence)
- Increased Involvement of the skin-oral tissue (e.g. generalized hives, itch-flush, swollen-lips-tongue-uvula)
- Persistent abdominal symptoms (e.g. crampy abdominal pain, vomiting)

If student has symptoms that progress into anaphylaxis:

- Administer Epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg (Jr)
☐ May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived
- Call 911 – Advise EMS that Epinephrine has been administered
- Stay with student
- After EAI administered, administer _____ (antihistamine) _____ (mg)
- If student has history of asthma and is coughing, wheezing, short of breath, and/or has chest tightness, after EAI, administer
☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)
☐ Levalbuterol 2 puffs (Xopenex®) ☐ Other _____
☐ May repeat every _____ minutes as needed for symptoms
- Notify school nurse and parent/guardian
- A Student given an EAI must be monitored by medical personnel or a parent/guardian and may NOT remain at school
☐ Student may carry EAI and/or antihistamine ☐ Student has demonstrated EAI use in LHP's office
☐ Student may self-administer EAI and/or antihistamine ☐ Student has demonstrated inhaler use LHP's office
☐ Student may carry and self-administer Inhaler

SIDE EFFECTS of medication(s):

LHP Signature _____		LHP Print Name _____	
Start date _____	End date ☐ Last day of school ☐ Other _____		
Date _____	Telephone _____	Fax _____	

EAI: increased heart rate. Antihistamine: sleepy Albuterol/Levalbuterol: increased heart rate, shakiness

(Allergy) Care Plan – Part 2 – Parent/Guardian (STUDENT): _____

BUS-TRANSPORTATION should be alerted to student's allergy.

◇ This student carries Rescue Medications on the bus: ☐ Yes ☐ No

- ◇ Medications can be found in ☐ Backpack ☐ Waistpack ☐ On Person ☐ Other (specify) _____
- ◇ Student will sit at front of the bus ☐ Yes ☐ No

FIELD TRIP Procedures – Medications must accompany student during any off campus activities.

- ◇ The student should remain with the teacher or parent/guardian during the entire field trip ☐ Yes ☐ No
- ◆ Staff members on trip must be trained regarding Epi-pen® use and this health care plan (plan must be taken).

CLASSROOM --For Food allergy only

- ◇ This student is allowed to eat only the following foods: _____
- ☐ Those in manufacturer's packaging with ingredients listed and determined allergen-free by the nurse/parent/guardian or _____
- ☐ Those approved by parent/guardian.
- ☐ Middle school or high school student will be making his/her own decision.
- ☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- ☐ Parent/guardian should be advised of any planned parties as early as possible.
- ☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ◇ Student should have someone accompany him/her in the hallways. ☐ Yes ☐ No

CAFETERIA ☐ **NO Restrictions**

- ☐ Student will sit at a specified allergy table.
- ☐ Student will sit at the classroom table cleansed according to procedure guidelines prior to student's arrival and following student's departure.
- ☐ Student will sit at the classroom table at a specified location.
- ◆ Cafeteria manager and hostess should be alerted to the student's allergy.

EMERGENCY CONTACTS

Pa ren t/G uar dia n	Name	Pa ren t/G uar dia n	Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
My child may carry and is trained to self-administer their EAI	☐ Yes ☐ No	Provide extra for office ☐ Yes ☐ No
My child may carry and is trained to self-administer their antihistamine	☐ Yes ☐ No	Provide extra for office ☐ Yes ☐ No
My child may carry and is trained to self-administer their rescue inhaler	☐ Yes ☐ No	Provide extra for office ☐ Yes ☐ No
My child may carry their EAI (needs assistance to administer)	☐ Yes ☐ No	

- ◆ I request this medication to be given as ordered by the licensed health professional (i.e.: doctor)
- ◇ I give Health Services Staff permission to communicate with the medical office about this medication. I understand that all medication will not necessarily be administered by a school nurse. It may be administered by school staff that have trained and are supervised by the school nurse.
- ◇ I release school staff from any liability in the administration of this medication at school.
- ◇ Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- ◇ All medication supplied will come in its originally provided container with instructions as noted above by the licensed health professional.
- ☐ This permission to possess and self-administer an Epinephrine auto-injector may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature

Date

For District Nurse's Use Only:

Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication.
Device(s) if any, used _____ Expiration date(s): _____

School Nurse Signature

Phone:

Date

The RN has completed a nursing assessment and developed this Care Plan in conjunction with this student, their parent/guardian and their LHP.

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.