Loomis Union School District
3290 Humphrey Road, Loomis, CA 95650 (916) 652-1800
www.loomis-usd.k12.ca.us
Building Excellence in Education since 1856
Erika Sloane, Superintendent

Health Care Plan (HCP) for: Anaphylaxis

SCHOOL YEAR _____

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name:		**Birthdate:**	**School:**
Teacher:	**Grade:**	**Date:**	**Does the Student have Asthma?** ⬜ **Yes** ⬜ **No** **If yes, student is at a higher risk for anaphylaxis*
Allergy to:		**Anaphylaxis may occur with:** ⬜ **Contact** ⬜ **Ingestion**	**Does this student need to sit at a peanut/nut free table?** ⬜ **Yes** ⬜ **No**

Contact information	
School Nurse: _____ 1.844.907.1005 (Fax)	**Parent(s):**

TO BE COMPLETED BY HEALTHCARE PROFESSIONAL:

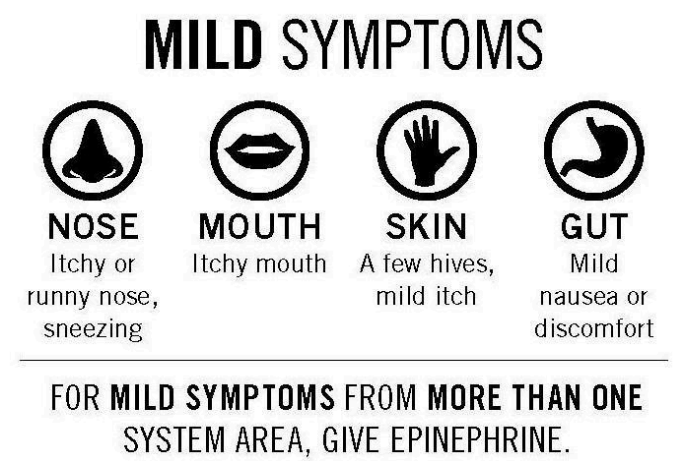
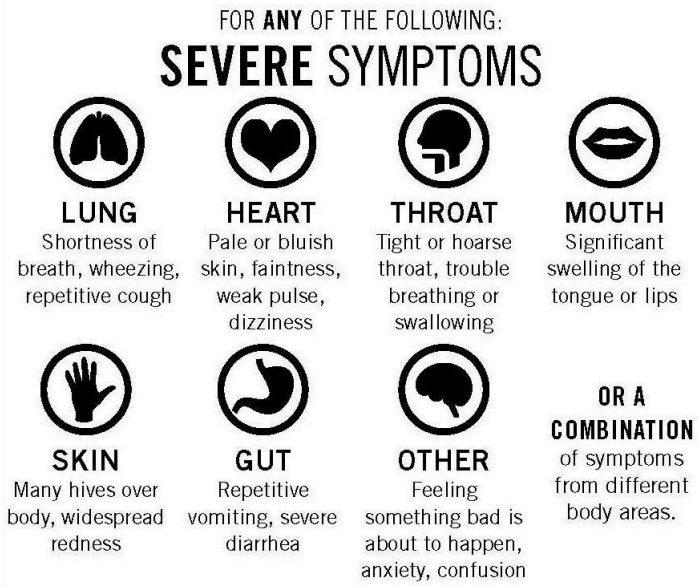
Name of Medication	**Directions *(include dose route, time, and frequency)***	**Self-Carry & Self-Administration** Has the health care provider instructed the student on the correct use of the medication and authorizes the student to **self-carry/self-administer** the medication?
Epinephrine Brand/Generic: _____	⬜ 0.1 IM ⬜ 0.15 IM ⬜ 0.3 IM	⬜ Yes ⬜ No **Provider Initials**: _____
Inhaler (Bronchodilator): _____		⬜ Yes ⬜ No **Provider Initials**: _____
Antihistamine Brand/Generic: _____		Not Applicable
Other: _____		Not Applicable

Self-Carry Procedures: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for self- administration of the medication as ordered by the provider. My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for the maximum of one year. If changes are indicated, I will provide new written orders and authorizations. Only applicable for **inhalers** or **epinephrine.**

Healthcare Provider Name (Printed): _____ **Address:** _____

Healthcare Provider Signature: _____ **Date:** _____

HEALTH CONCERNS AND PROCEDURES FOR MEDICAL ACTION WHILE AT SCHOOL

Observe This:	**Do This:**
	For **MILD SYMPTOMS** from a **SINGLE SYSTEM**, Follow the directions below *Do **NOT** depend on antihistamines and bronchodilators (inhalers) to treat a severe reaction, give Epinephrine (see below) 1. Give antihistamines, if ordered by a healthcare provider 2. Stay with the student and alert the emergency contacts 3. Watch the student closely for changes. If symptoms worsen or the student develops symptoms from another system are, give EPINEPHRINE (see below for directions)
Observe This:	**Do This:**
	For SEVERE SYMPTOMS or MULTI-SYSTEM symptoms, Follow the directions below 1. **INJECT EPINEPHRINE IMMEDIATELY** 2. **CALL 911** - Tell the dispatcher that the student is having anaphylaxis and may need Epinephrine when the emergency responders arrive 3. Consider giving additional medications following epinephrine: a. Inhaler (bronchodilator) - if the student is wheezing or still struggling to breath b. Antihistamines 4. Lay the student flat, raise their legs, and keep them warm. If the student is having difficulty breathing or is vomiting, let them sit up or position them in the side-lying recovery position 5. If symptoms do NOT improve or symptoms return, give an additional dose of epinephrine 5-10 minutes after the last dose 6. Alert the emergency contacts 7. **The student MUST be taken to the ER** (even if symptoms resolve). The student must be observed for at least 4 hours because symptoms may return

I authorize the school nurse and/or other trained school personnel to assist my child in taking his/her medications and treatments, and I authorize the nurse to consult with the Health Care Provider about my child's medical needs as necessary while my child is at school. I understand it is my responsibility to provide all medication, supplies and equipment and understand that if my child carries his own medication I should provide extra to be kept in the office in case needed.

I will be provided with a copy of my child's completed Health Care Plan. I have read and agree with the information provided above. I understand and give my consent for this information to be shared with the student's school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one school year and may be revoked at any time.

Parent Signature: _____ **Date:** _____

Reviewed By:

School Nurse: _____ **Date:** _____

Principal: _____ **Date:** _____

For Office Use only:

☐ **Aeries** ☐ **Teacher Copy** ☐ **Cume Copy** ☐ **Photo** ☐ **Added to Report Sheet**