School District of Manawa

Student Health Services
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Anaphylaxis/Allergy Management Plan 2017/2018

Student Name _____ Date of Birth _____

School _____ Teacher _____

Student ID # _____ Grade _____

Home Street Address_____

City_____ State _____Zip Code_____

Parent/Guardian Name _____

Parent/Guardian Name _____

Please keep all parent/guardian and emergency contact information current with school office staff. In the event of an emergency we will attempt to contact parents/guardians followed by emergency contacts in the order on file.

Allergy to:_____ Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

Complete information in this box if your child is EXTREMELY REACTIVE

Extremely reactive to the following foods/medications/insects/nonfood items (ex. latex): _____
Therefore:

☐ If checked give epinephrine and call 911 immediately for **ANY symptoms** if the allergen was **LIKELY** eaten or come into contact with.

☐ If checked give epinephrine and call 911 immediately if the allergen was **DEFINITELY** eaten or come into contact with **EVEN IF NO SYMPTOMS ARE NOTED**.

Medications to be given at school for allergy/anaphylaxis:
Epinephrine Type/Brand:_____

Epinephrine Dose: ☐ 0.15 mg injection IM ☐ 0.3 mg injection IM

Antihistamine-medication name/dose/route : _____

Other-medication name/dose/route: _____

Describe known symptoms from any previous insect sting, food ingestion, or reaction to nonfood item(s): _____

For MILD symptoms after suspected or known ingestion, sting, or contact:
Nose: Itchy/runny nose, sneezing
Mouth: Itchy mouth
Skin: A few hives, mild itch
Gut: Mild nausea/discomfort

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1. Antihistamine may be given if ordered by a provider and kept at school for student.
2. Stay with person and monitor for changes.
3. If symptoms worsen, give epinephrine
4. Alert parent/guardian or emergency contact.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA GIVE EPINEPHRINE and CALL 911

Turn Over

For any SEVERE SYMPTOMS (one or more of the following) after suspected or known ingestion, sting, or contact you must not delay treatment:

Lungs: Shortness of breath, wheezing, repetitive cough
Heart: Faint/dizzy, passing out, weak pulse, pale or cyanotic (blue) skin
Throat: Tightness, itching, hoarse, trouble breathing/swallowing
Mouth: Swelling of the tongue or lips
Skin: Many hives over body, widespread redness or itching, swelling of face or body
Gut: Repetitive vomiting, severe diarrhea
Other: Sense of impending doom (something bad is going to happen), confusion

1. **Inject epinephrine immediately.**
2. **Call 911**
3. Consider giving additional medications if included in plan:
   a. Antihistamine
   b. Other
4. Lay person flat with legs elevated. If breathing is difficult or student is vomiting allow them to sit up or lie on their side.
5. If symptoms don't improve or worsen after 5 minutes, give a second dose of epinephrine if available.
6. Alert parent/guardian or emergency contact.

*Remember antihistamines/inhalers cannot be depended on in anaphylaxis

If student is in 7th grade or older and may carry and self-administer allergy/anaphylaxis medications parent must complete the information in this box:

Release from Responsibility for Self-Administration of Medication:

I, _____, hereby give authority for _____, to carry and administer his/her
(Parent/Guardian Name) (Student Name)

own epinephrine during school hours.

I release the school from any responsibility regarding medication errors incurred during school hours. I further understand that my child must carry the medication in its original container with the original prescription label containing the medication name and student's name affixed.

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Furthermore, I agree to:

1. Provide the necessary supplies and equipment.
2. Notify the school staff or school district nurse of any changes in the student's health status.
3. Notify the school staff and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
5. School staff interacting directly with my child may be informed about this health care plan.
6. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.
7. Hold without liability the School district of Manawa, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the 2017/2018 school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____