



# School District of Manawa

## Student Health Services

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### Allergy/Anaphylaxis Management Plan for School Year:

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School Building \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name and Phone Number(s) \_\_\_\_\_

Parent/Guardian Name and Phone Number(s) \_\_\_\_\_

Emergency Contact Name and Phone Number(s) \_\_\_\_\_

Allergy to: \_\_\_\_\_

Asthma:  YES (higher risk for severe reaction)  NO

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

**Complete information in this box if your child is EXTREMELY REACTIVE**

Extremely reactive to the following foods /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 (IN ORDER BELOW) for allergy/anaphylaxis:

Epinephrine Auto-Injector Type/Brand: \_\_\_\_\_

Epinephrine Dose:  0.15 mg injection IM  0.3 mg injection IM

Antihistamine-medication name/dose: \_\_\_\_\_

Other-medication name/dose/route: \_\_\_\_\_

**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



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**

**For any SEVERE SYMPTOMS (ANY 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, weak pulse, pale or cyanotic (blue) skin  
Throat: Tightness, hoarse, trouble breathing/swallowing  
Mouth: Significant swelling of the tongue or lips  
Skin: Many hives over body, widespread redness  
Gut: Repetitive vomiting, severe diarrhea  
Other: Sense of impending doom (something bad is going to happen), confusion

Or any combination of these.



1. **Inject epinephrine immediately.**
  2. **Call 911, state student is having anaphylaxis**
  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 alone in anaphylaxis

**Parent consent for management of health condition while at school or other school-sponsored 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, including medication in the original, pharmacy labelled container.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify the school staff or school district nurse of any changes in the student's health status.
4. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
5. Ensure this form is signed by the appropriate medical provider (provider who manages the medical condition).
6. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition.
7. School staff interacting directly with my child may be informed about this health care plan.
8. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
9. 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 pertaining school year)  
\_\_\_\_\_ Date \_\_\_\_\_

**Physician Information**

Print Name of Provider \_\_\_\_\_ Institution Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Address \_\_\_\_\_

- ONLY FOR STUDENTS IN 5<sup>th</sup> GRADE AND UP** I have instructed the student in the proper way to use his/her medications. **It is my opinion that he/she should be allowed to carry and administer epinephrine by him/herself.**
- It is my opinion that the student should not carry nor administer his/her epinephrine by him/herself.**

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_

School RN Signature \_\_\_\_\_ Date \_\_\_\_\_