LIFE THREATENING ALLERGY Emergency Care Plan

☐ ☐

Student Name:				DOB:	
School:	Bellevue Children's Academy	School Year:		Grade:	
Teacher:					

MEDICAL INFORMATION

Asthma ☐ Yes (High Risk for Severe Reaction) ☐ **No**

List specific symptoms student experienced in the past and date of last reaction (if no symptom or date, please write none)

Severe Allergies and Other Allergies	Specific Symptoms	Date of Last Reaction

ALLERGY SYMPTOMS: If you suspect a severe allergic reaction, IMMEDIATELY ADMINISTER EPINEPHRINE AND CALL 911

Epinephrine auto-injector/s stored ☐ School Clinic ☐ With Student ☐ In Classroom ☐ Coach ☐ other

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth	**LUNG**	Shortness of breath, repetitive coughing, and/or wheezing
SKIN	Hives, itchy rash, and/or swelling about the face or extremities	**HEART**	"Thready" pulse, "passing out," fainting, blueness, pale
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough	**GENERAL**	Panic, sudden fatigue, chills, fear of impending doom
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea	**OTHER**	Some students may experience symptoms other than those listed above

EMERGENCY PLAN

Medication Orders - This section to be completed by a LICENSED HEALTHCARE PROVIDER (HCP):

If the student has symptoms or you suspect exposure (insect sting, eats something s/he allergic to or exposed to allergen:)

1. **Give Epinephrine auto-injector** ☐ **0.3 mg** ☐ **0.15 mg** injected in outer thigh
   Repeat dose of Epinephrine auto-injector, if available. ☐ **Yes** ☐ No **If "Yes", when:** _____
2. **Stay with student.**
3. **CALL 911** - Advise Emergency Services that student has been given Epinephrine for a severe allergic reaction.
4. **Notify parent/guardian and school nurse.**
5. **After Epi auto-injector is given, give Antihistamine**
   ☐ **Benadryl/diphenhydramine** _____ teaspoons of 12.5mg/5ml or _____ mg tablet by mouth or Other:
6. **If student has a history of asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction:**
   After Epi auto-injector and antihistamine, give: Albuterol _____ **puffs by mouth** or Other:
7. **A student given an Epi auto-injector must be monitored by medical personnel or a parent and may NOT remain at school.**

Side Effects: Epi-auto injector: Increased heart rate, other: Antihistamine: Sleepiness, other:
Inhaler: Increased heart rate, shakiness, other:

☐ **Yes** ☐ **No** **It is medically necessary for this student to self-carry allergy medication during school hours.**

☐ Student has demonstrated correct Epi auto-injector use to HCP and may carry and self-administer Epi auto-injector.

☐ Student has demonstrated correct antihistamine use to HCP and may carry and self-administer antihistamine.

☐ Student has demonstrated correct inhaler use to HCP and may carry and self-administer inhaler.

Medication orders and treatment plan expiration date: ☐ End of current school year ☐ Other:

Healthcare Provider's Signature: _____ ☐ Signature on File Date: _____

Healthcare Provider's Name:	HCP Phone:	HCP Fax:

LIFE THREATENING ALLERGY Emergency Care Plan SEVERE ALLERGY TO
STUDENT NAME

INDIVIDUAL CONSIDERATIONS

This section to be completed by parent/guardian.

TRANSPORTATION/BUS

Transportation will be alerted to the student's allergy.

☐ Walker ☐ Car ☐ Bus Rider - Bus Number:

Epinephrine auto-injector can be found ☐ None on bus ☐ Backpack ☐ On Student ☐ Other:

Other Instructions:

OFF CAMPUS ACTIVITIES/FIELD TRIPS

- Epinephrine auto-injector and care plan must accompany the student during any off campus activities.
- Student must remain with a trained teacher or parent/guardian during the entire field trip unless authorized to carry and self-administer medications.
- A staff member on trip must be trained regarding Epinephrine auto-injector use and this care plan.
- Other Instructions:

CLASSROOM - FOR FOOD ALLERGIES ONLY

NOTE: **Meals and food from home provide the safest food option at school.**

☐ Yes ☐ No Student is responsible for making his/her own food decisions

- Student ***is not*** allowed to eat the following foods:
- Student may eat foods in manufacturer's packaging with ingredients listed & determined to be allergen-safe by the
- ☐ school nurse ☐ teacher ☐ parent/guardian ☐ student ☐ Other:
- Suggested alternative snacks approved by parent/guardian:
- ☐ Yes ☐ No 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.

CAFETERIA

☐ No Restrictions

☐ Restrictions needed

The Cafeteria Staff will be alerted to the student's allergy.
Other Instructions:

OTHER ACCOMMODATIONS - MODIFICATIONS

PARENT/GUARDIAN INFORMATION

Guardian 1:	Home Phone:	Work Phone:	Cell Phone:
Guardian 2:	Home Phone:	Work Phone:	Cell Phone:

EMERGENCY CONTACTS AND HOSPITAL INFORMATION

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Preferred Hospital

LIFE THREATENING ALLERGY Emergency Care Plan SEVERE ALLERGY TO

STUDENT NAME

PARENT/GUARDIAN CONSENT - You must complete and **SIGN**

☐ I request that authorized school personnel assist my child to take the medicine(s) described above. (If no box is checked, this option is the default.)

☐ I request that my child be permitted to self-administer the medicine(s) described above. I will hold harmless and indemnify the District, its officers, employees and personnel against all claims or liability arising out of the student's self-administration or carrying of medication.

☐ I am at least 18 years old and sign this form on my own behalf (RCW 26.28.015 or RCW 70.02.130).

My signature indicates my permission for the exchange of information between school staff and the health care provider, and my understanding that the District and school staff will not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and Washington law. I understand this is a plan for a life threatening condition and can only be discontinued, in writing, by a health care provider.

The permission to possess and self-administer medication may be revoked by the principal or school nurse if it is determined that your child is not safely and effectively possessing and self-administering medication.

**** It is strongly recommended that extra medication be provided and stored in the school clinic. ****

PARENT SIGNATURE:	☐ Parent/Guardian Signature on File	**Date**

School Nurse and Administrator - Complete this section.

Student has demonstrated to the school nurse the skill necessary to use the medication and any device necessary to self-administer the medication.	☐ Yes ☐ No
Student has permission from administrator to carry and self-administer medications approved by licensed healthcare provider.	☐ Yes ☐ No

School Nurse		☐ Nurse's Signature on File	Date:	
Administrator		☐ Administrator's Signature on File	Date:	

A copy of this plan is available in Skyward and will be kept in the school health room and copies will be given to:

☐ Teacher ☐ PE Department ☐ Cook ☐ Nutrition Services ☐ Transportation ☐ Other