Optional Student Photo

ALLERGY ANAPHYLAXIS CARE PLAN *Side 1*

TO BE COMPLETED BY HEALTHCARE PROVIDER

EFFECTIVE DATE:		**END DATE**:
STUDENT'S NAME:	**Grade**:	Date of Birth:
HEALTHCARE PROVIDER INFORMATION Name:		
Phone #: Fax #:		
SCHOOL:	**Nurse phone #**:	**Fax #**:

ALLERGIES/ANAPHYLAXIS: _____

☐ **YES** ☐ **NO** **Does this student have asthma?** (Having asthma increases the risk of having a more severe allergic reaction.)

☐ **YES** ☐ **NO** **Has this student received instruction on the proper use of his/ her auto-injector?**

☐ **YES** ☐ **NO** **Is this student able to safely carry & self- inject an EpiPen auto-injector if needed during school hours?**
(If this student is not able to self-treat, a nurse or trained adult may administer EpiPen auto injector)

Non-Anaphylaxis Allergic Reaction Symptoms

☐ Hives ☐ Scratchy throat ☐ Itching ☐ Rash ☐ Nasal Congestion ☐ Watery or itchy eyes

Anaphylaxis Allergic Reaction Symptoms

☐ Abdominal pain or cramping ☐ Pain or tightness in the chest ☐ Diarrhea ☐ Wheezing or coughing

☐ Swelling of the eyes, face, or tongue ☐ Heart palpitations or racing ☐ Dizziness ☐ Nausea or vomiting

☐ Difficulty swallowing or talking ☐ Sense of impending doom ☐ Unconsciousness ☐ Shortness of breath

MEDICAL PROVIDER AUTHORIZATION

(Provider have parent/guardian sign Authorization & Agreement page 2-2)

MINOR ALLERGIC REACTION SYMPTOMS	SEVERE ALLERGIC REACTION SYMPTOMS	
✓ Hives (itchy red spots on the skin)	✓ Abdominal cramping or pain	✓ Flushing of face
✓ Scratchy throat	✓ Pain or tightness in the chest	✓ Nausea or vomiting
✓ Itching	✓ Diarrhea	✓ Difficulty swallowing or talking
✓ Rash	✓ Wheezing or coughing	✓ Sense of impending doom
✓ Nasal congestion (known as rhinitis)	✓ Swelling of the face, eyes, or tongue	✓ Unconsciousness
✓ Watery or itchy eyes	✓ Heart palpitations or racing	✓ Shortness of breath
	✓ Dizziness, vertigo, or lightheadedness	

MEDICATION	DOSE	ROUTE	NOTES
☐ Antihistamine (type) _____	_____	Oral	For **minor** allergic reaction
☐ Epinephrine Auto-injector	_____ mg	IM Injection	For **severe** allergic reaction
☐			

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

ALLERGY ANAPHYLAXIS CARE PLAN *Side 2, Continued:*

TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

Student Name: _____ **Birthdate:** _____

Optional Student Photo

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis. Please select components you would like the school to implement for your child:

- ☐ Notify nurse, teacher(s), front office and kitchen staff of known allergies
- ☐ I want my student to sit at a "Allergy Free" table in the cafeteria
- ☐ Post "Allergy Free" signage at entrance of classroom (Elementary Schools Only)
- ☐ I give permission for my student to sit anywhere in the cafeteria
- ☐ **Other:**

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

☐ I want this plan implemented and **I authorize (along with consent from health care provider) for my child to carry & self-administer their epinephrine auto-injector.**

-OR-

☐ I want this plan implemented and **I DO NOT authorize my child to carry and self-administer their epinephrine auto-injector**. Medications will be stored and administered/supervised by the school nurse.

-OR-

☐ My child's allergies have been reviewed by a health care provider and it has been determined that he/she does **NOT** need an epinephrine auto-injector at this time.

Training:

☐ **I request that school staff be trained in how to give emergency medications to my child in the absence of the nurse.**

I request that the medication(s) selected and allergy/ anaphylaxis protocols listed on this plan be provided to my child. **I will provide needed medications or supplies for care in school. I understand that prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.** I will notify KIBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and KIBSD as part of the provision of my child's care. I agree for the nurse to share health information with KIBSD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the KIBSD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

STUDENT SELF-CARRY AGREEMENT

I have been trained in the use of my EpiPen auto-injector and allergy medication. I understand the signs and symptoms of an allergic reaction and agree to have my EpiPen auto-injector available at all times. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if I use my EpiPen auto-injector. I will not share my medication with other students or leave my medication unattended. I will use my allergy medication only for the prescribed purpose.

STUDENT NAME (PRINTED)	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW

☐ **Approved by School Nurse.** Back up medication is stored at school ☐ Yes ☐ No

Trained Staff Name	***Title***	***Location/Rm #***	***Trained by (RN only)***

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE