



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	
<input checked="" type="checkbox"/> Hives (itchy red spots on the skin) <input checked="" type="checkbox"/> Scratchy throat <input checked="" type="checkbox"/> Itching <input checked="" type="checkbox"/> Rash <input checked="" type="checkbox"/> Nasal congestion (known as rhinitis) <input checked="" type="checkbox"/> Watery or itchy eyes	<input checked="" type="checkbox"/> Abdominal cramping or pain <input checked="" type="checkbox"/> Pain or tightness in the chest <input checked="" type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Wheezing or coughing <input checked="" type="checkbox"/> Swelling of the face, eyes, or tongue <input checked="" type="checkbox"/> Heart palpitations or racing <input checked="" type="checkbox"/> Dizziness, vertigo, or lightheadedness	<input checked="" type="checkbox"/> Flushing of face <input checked="" type="checkbox"/> Nausea or vomiting <input checked="" type="checkbox"/> Difficulty swallowing or talking <input checked="" type="checkbox"/> Sense of impending doom <input checked="" type="checkbox"/> Unconsciousness <input checked="" type="checkbox"/> Shortness of breath

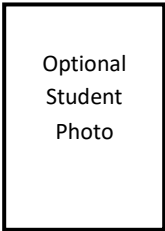
MEDICATION	DOSE	ROUTE	NOTES
<input type="checkbox"/> Antihistamine (type) _____	_____	Oral	For minor allergic reaction
<input type="checkbox"/> Epinephrine Auto-injector	_____ mg	IM Injection	For severe allergic reaction
<input type="checkbox"/>			

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:** _____



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
- Post "Allergy Free" signage at entrance of classroom (Elementary Schools Only)
- I want my student to sit at a "Allergy Free" table in the cafeteria
- 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

<u>Trained Staff Name</u>	<u>Title</u>	<u>Location/Rm #</u>	<u>Trained by (RN only)</u>

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE

