Individualized Health Care Plan **Student Name:** **School Year:**

Anaphylaxis (Severe Allergy) Individualized Healthcare Plan

SECTION I			
Student:			WT: HT:
Grade:	D.O.B	Any Known Allergies	
School:			
District:		Bus (check one) ☐YES ☐NO Bus #AM	Bus #PM
School Nurse:		Pager #	Cell #
Medication taken at home: (please list)			

Contacts			
Mother	Home #	Work #	Pager/Cell #
Father	Home #	Work #	Pager/Cell #
Guardian/Custodian	Home #	Work #	Pager/Cell #
Home Address		City #	Zip
Emergency Contact (Relationship)		Home #	Work #
Physician		Phone #	Fax#
Physician Address		City	Zip

Date	Special Notes

Individualized Health Care Plan **Student Name:** **School Year:**

Anaphylaxis (Severe Allergy) Individualized Healthcare Plan

SECTION II: EMERGENCY ACTION PLAN

IF YOU SEE THIS....		DO THIS....
Contact with or ingestion of allergen with no symptoms:		Administer medication? ☐ Yes ☐ No Medication: _____ Medication dosage: _____ Call parent or emergency contact. Observe student for ____minutes before return to class. Recheck student in 1 hour.
Symptoms of **MILD** or **EARLY** allergic reaction:	Itching Hives No Respiratory Distress	Administer medication? ☐ Yes ☐ No Medication: _____ Medication dosage: _____ Other: _____ Call parent or emergency contact. Observe student for ____ minutes before return to class.
Symptoms of **SEVERE allergic reaction**:	Mouth, lips or face tingling Feels throat is closing Cough, Wheeze, Stridor **Respiratory distress** Weak pulse, Low BP, Pallor, Sweating Abdominal cramps, Nausea **Loss of Consciousness**	**Call 9-1-1** Administer Epinephrine? ☐Yes ☐ No ☐ Epipen: ☐0.3 mg ☐0.15 mg ☐ Other epinephrine Rx: ☐0.3 mg ☐0.15 mg Other: _____ Contact Parent/Emergency Contact. Remain with student until EMS personnel arrive. Be prepared to administer second dose of epinephrine, if ordered by prescriber and available.

STEPS FOR ADMINISTERING EPINEPHRINE AUTOINJECTOR:

1. Remove blue safety cap.
2. Place orange tip against lateral thigh (Do NOT touch orange tip)
3. Press orange tip into lateral thigh, through clothing until hear "click"
4. Hold autoinjector in place for count of "10"
5. Pull autoinjector straight away from thigh.
6. Gently massage injection site for 10 seconds.
7. Record date/time administered on autoinjector.
8. Give EMS personnel used autoinjector.

***ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER**

School Nurse Use Only

*Medication	Expiration Date	Self-Carry?	Location of Medication

Notes /Special Instruction _____

_____

Individualized Health Care Plan **Student Name:** **School Year:**

Anaphylaxis (Severe Allergy) Individualized Healthcare Plan

SECTION III:

Anaphylaxis is a rare, life-threatening allergy to certain substances such as foods, bee stings, chemicals and medications. It occurs rapidly and can close off the breathing passages. **Exposure to this substance should be avoided, including skin contact, at all times! AVOID EXPOSURE TO FOLLOWING ALLERGEN(S):**

MEDICATION(S) AT SCHOOL:	**POTENTIAL SIDE EFFECTS:** (Notify school nurse)
□ Epinephrine Auto-injector: □ Carried On-Person? Self-Administer? □ YES □ NO □ YES □ NO	Rapid heart rate
□ Oral Antihistamine (name): Carried On-Person? Self-Administer? □ YES □ NO □ YES □ NO	Drowsiness
Other meds at school :	
MEDICATION(S) AT HOME:	**POTENTIAL SIDE EFFECTS:** (Notify school nurse)

CLASSROOM:	**PHYSICAL EDUCATION:**
□ Inform all parents classroom is "allergy aware" listing all known allergens (sign outside classroom door, newsletters, etc.) □ Instruct students to wash hands w/soap & running water before & after meals/snacks □ Adult to wipe down tables/desks after meals & snacks, using household cleaning wipe □ Avoid learning activities that include allergens □ Contact School Nurse immediately if student develops symptoms of severe allergy per Emergency Action Plan on previous page	□ Avoid contact with balls and other equipment that contain latex □ Remain alert for stinging insect nests/mounds & notify Plant Manager immediately if nests discovered. Keep students away from area. □ Contact School Nurse immediately if student develops symptoms of severe allergy per Emergency Action Plan on previous page □ Other:
Classroom Snacks: (STUDENTS ARE **NOT** TO SHARE FOOD DURING MEALS OR SNACKS) □ Student will bring own snack □ Student will select from allergen-free options in classroom supply	

FIELD TRIPS:	**BUS TRANSPORTATION:**
□ Hand wipes to be used before & after meals or snacks if no soap & water available on trip	□ Driver will wipe down student's assigned bus seat before & after route
If student **IS** authorized to self-carry and self-administer allergy medications:	If student **IS** authorized to self-carry and self-administer allergy medications:
□ Student will keep meds on person at all times □ Student will notify teacher immediately if is exposed to allergen &/or develops symptoms □ Teacher to assist student as necessary, call 9-1-1 and then contact parent	□ Student will keep meds on person at all times □ Student will notify driver if exposed to allergen &/or develops symptoms □ Driver will assist student as necessary and procedure for activating EMS & parent
If student **IS NOT** authorized to self-carry & self-administer allergy medications:	If student **IS NOT** authorized to self-carry & self-administer allergy medications:
□ Nurse or Medication Assistant will accompany trip with medication & orders on person □ Student will have ready access to Nurse or Medication Assistant for duration of trip	

EMERGENCY DRILLS AND SCHOOL CRISIS EVENTS	**OTHER:**
□ School Nurse will secure medications & orders in accordance with school safety plan □ In event of building evacuation, School Nurse or Med Asst will evacuate w/medications & orders □ If so authorized, student will keep meds on person for duration of drill or crisis event □ Student requires assistance during building evacuation? □ NO □ YES If "yes", describe:	After School Activity: (Describe)

Individualized Health Care Plan **Student Name:** **School Year:**

Written Notes/Addendum to Plan of Care

DATE		PARENT/ GUARDIAN INTIALS (if needed)

I understand and agree with this Individualized Healthcare Plan.

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.

I give permission for the release of my child's medical information, in the event of an emergency.

Signature of Parent or Guardian **Date**

Signature of School Nurse **Date**

Individualized Health Care Plan **Student Name:** **School Year:**

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies—if drug allergies list:** _____ **Weight:** _____**pounds**

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____**Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____**Phone:** ( )_____-_____ **Fax:** _____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____**Date:** ___/___/___ **Phone:** ( )_____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone:** ( )_____-_____

Individualized Health Care Plan **Student Name:** **School Year:**

Communication of the Individualized Health Care Plan

SECTION IV:

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns.

Employee Name	Employee Signature	Position	Date