RCSD ROSEVILLE CITY SCHOOL DISTRICT Est. 1869

ANAPHYLAXIS ACTION PLAN To be completed by PHYSICIAN

Place Photo Here

NAME: _____Birthdate: _____

Allergic To:_____

Weight: _____lbs. History of Asthma: Yes ☐ (*more risk for severe reaction) No☐

Student may self-carry/self-administer medications: Yes ☐ No ☐

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

_____ _____ _____ _____

Physician Signature Date Name (Printed) Phone

_____ _____

Parent Signature Date

Parent/Guardian (Authorization and Disclaimer): Per my signature above, I request that the school assist my child with the above medications in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer above medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of above medications. I authorize staff to communicate with the physician regarding my child's medical condition and/or the medications prescribed for it. ***I have read and agree with the information provided above. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one year from date unless otherwise stated and may be revoked at any time.**

RCSD ROSEVILLE CITY SCHOOL DISTRICT
Est. 1869

Individualized School Health Care Plan for Students with Severe Allergies
Student Demographic Information and Health History
(This portion to be completed by parent)

PLEASE SEE REVERSE SIDE FOR EMERGENCY ANAPHYLAXIS ACTION PLAN TO BE COMPLETED BY PHYSICIAN

Last Name:_____ **First Name:**_____

Date of Birth (mm/dd/yyyy):_____School:_____Teacher/Grade:_____

Parent/Guardian Name:_____Parent/Guardian Phone #:_____

Other Emergency Contact:_____Other Emergency Phone #:_____

Health Care Provider Name:_____Health Care Provider Phone #:_____

SEVERELY ALLERGIC TO:_____

History of Allergic Reactions

What was the allergen:_____Total reactions:_____

Treatment provided:_____Date of last reaction:_____

Other medical information (check if applicable): ❑ Asthma ❑ Inhaler at school ❑ Medical ID worn

How soon after contact does your child react? _____ minutes_____ hours_____ days

Please indicate symptoms that your child has experienced with previous reactions (mark all that apply):

☐All over tingling or itching	☐Vomiting, stomach cramping or diarrhea
☐All over rash or hives	☐Wheezing or difficulty breathing
☐Coughing or sneezing	☐Blue or gray discoloration of lips or fingernails
☐Sudden mood change	☐Dizziness or fainting
☐Red face	☐Seizures
☐Tightness of throat and/or chest	☐Loss of consciousness
☐Swelling of eyes, lips, tongue, throat or neck	☐Other_____

What are the early warning signs that indicate your child is starting to have an allergic reaction?

Does he or she recognize these warning signs? ☐Yes ☐No

Does your child know how to avoid known allergens (causes of allergic reactions)? ☐Yes ☐No

Please mark what your child does to prevent or avoid an allergic reaction:

- ☐ Knows what to avoid (list:_____).
- ☐ Tells others about his or her allergies
- ☐ Tells an adult **immediately** if exposed to an allergen
- ☐ Asks about ingredients in foods, if unsure about contents
- ☐ Firmly refuses food that might be a problem food

Does this student need to sit at a peanut/nut free table: ☐ **Yes** ☐ **No**

Teacher will notify parent in advance of parties/special food in the classroom. Parent will determine whether their student can eat food being provided and/or provide a safe alternative snack

Form completed by _____Relationship to child_____

Parent Signature _____Date_____

Parent/Guardian (Authorization and Disclaimer): Per my signature above, I request that the school assist my child with the medications included the Anaphylaxis Action Plan in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer above medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of above medications. I authorize staff to communicate with the physician regarding my child's medical condition and/or the medications prescribed for it. ***I have read and agree with the information provided above. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one year from date unless otherwise stated and may be revoked at any time.**

(To be completed by school nurse)

Location of emergency medications:_____

*School Nurse signature:*_____ *Date*

*Principal Signature:*_____ *Date*

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Dear Parent,

Your school nurse is currently working to address specific health needs for students in the upcoming school year. You are receiving this letter because you indicated on your child's registration paperwork that your child has a severe allergy and/or epinephrine. Enclosed, please find the Individualized School Health Care Plan for Students with Severe Allergies.

The first side is the Student Demographic Information and Health History, to be completed by the parent to provide information regarding the history and severity of your child's severe allergy and symptoms they have experienced with previous reactions.

The Anaphylaxis Action Plan is a form that provides specific instructions regarding your child's medications and emergency plan for school. This form is for your physician to complete and sign with orders regarding the administration of medication and actions to be taken by school personnel, in the event of an allergic reaction.

Please take the time to review and complete this form with your physician and return it to the school office as soon as possible, along with any indicated medications (all medications must be in the original container and prescription medications must have a prescription label; it is the parent's responsibility to replace medications that will expire during the course of the school year prior to the expiration date). Once your school nurse receives the form, along with appropriate medications, and reviews the doctor's orders, the completed healthcare plan will be shared with your child's teacher(s) and other staff responsible for their supervision and care.

This health plan will need to be updated annually, and it is the parent's responsibility to provide the school with updated medication orders from their physician and current medication each year. This form is also available on the district website:

To access forms on-line:

- Go to the district website www.rcsdk8.org
- In upper right corner of page, click on the white circle with 3 horizontal lines
- Click on Medical Forms - middle column, near bottom of list
- Select the appropriate form from the options to the right

Please feel free to call or e-mail your school nurse with any questions or concerns, or if you would like to schedule a meeting to review your child's healthcare plan for school.

Respectfully,
Your District Health Services Team