

Date Plan was Developed: _____

COLTON SCHOOL DISTRICT

**SEVERE ALLERGY (NON-FOOD)
LICENSED HEALTH PROFESSIONAL (LHP) ORDERS / CARE PLAN**
(Must be completed legibly by a licensed health professional)

NAME		Severe ALLERGY to BEE STINGS	
Student should avoid contact with this/these allergen(s)		Other allergies:	
School	Birthdate	Grade	Routine medications (at home/school)
Bus # _____	Car <input type="checkbox"/>	Walk <input type="checkbox"/>	
Asthmatic? (High risk for severe reaction): <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of last reaction:	
Please list the specific symptoms the student has experienced in the past:			

ACTION PLAN / LHP ORDERS

If you suspect a severe allergic reaction to bees, immediately determine the symptoms and treat the reaction as follows:

Symptoms (known symptoms 'X')

- | | |
|----------------------------------|--|
| <input type="checkbox"/> MOUTH | Itching, tingling, or swelling of the lips, tongue, or mouth |
| <input type="checkbox"/> SKIN | Hives, itchy rash, and/or swelling about the face or extremities |
| <input type="checkbox"/> THROAT | Sense of tightness in the throat, hoarseness and hacking cough |
| <input type="checkbox"/> GUT | Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea |
| <input type="checkbox"/> LUNG | Shortness of breath, repetitive coughing, and/or wheezing |
| <input type="checkbox"/> HEART | "Thready" pulse, "passing out", fainting, blueness, pale |
| <input type="checkbox"/> GENERAL | Panic, sudden fatigue, chills, fear of impending doom |
| <input type="checkbox"/> OTHER | _____ |

Give Medication (X)

- | |
|---------------------------------|
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |
| <input type="checkbox"/> Epipen |

Medication Doses

Epipen (.03)	_____	Epipen Jr. (0.15)	_____	Side Effects:
Repeat dose of Epipen: <input type="checkbox"/> Yes <input type="checkbox"/> No				If YES, when

- ◆ **Call 911 immediately. 911 must be called if Epipen is administered.**
- ◆ **DO NOT HESITATE to administer Epipen and to call 911 even if the parents cannot be reached.**
- ◆ Advise 911 dispatch that the student is having a severe allergic reaction and Epipen is being administered.
- ◆ It is medically necessary for this student to carry an Epipen during school hours. Yes No
- ◆ Student may administer Epipen. Yes No
- ◆ Student has demonstrated use to LHP. Yes No

Location(s) where Epi-pen/Rescue medications is/are stored:

- Office Backpack On Person Coach Other _____

	Start Date:	End Date:
Licensed Health Professional's Signature	Today's Date:	
	Phone:	
Licensed Health Professional's Printed Name	Fax Number:	

Licensed Health Professional (LHP) Orders / Care Plan for Severe Allergy – Part 2

- ◆ Student should remain quiet with a staff member at the location where the symptoms began until EMS arrives.
- ◆ Notify the administrator and parent/guardian.
- ◆ Provide a copy of the Emergency Care Plan to EMS upon arrival.

Individual Considerations

Bus –Transportation should be alerted to student's allergy.

- ◆ This student carries Epipen on the bus Yes No

- ◆ Epipen can be found in Backpack Waistpack On Person Other (specify) _____
- ◆ Student will sit at front of the bus Yes No
- ◆ Other (specify) _____

Field Trip Procedures – Epipen should accompany student during any off campus activities.

- ◆ The student should remain with the teacher or parent/guardian during the entire field trip Yes No
- ◆ Staff members on trip must be trained regarding Epipen use and this health care plan (plan must be taken).
- ◆ Other (specify) _____

CLASSROOM

- Middle school or high school student will be making his/her own decision.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ◆ Student should have someone accompany him/her in the hallways. Yes No
- ◆ Other (specify) _____

CAFETERIA

- ◆ Cafeteria manager and hostess should be alerted to the student’s allergy.
- ◆ Other _____
- NO Restrictions**

EMERGENCY CONTACTS

Mother/Guardian	Name	Father/Guardian	Name
	Home Phone		Home Phone
	Work Phone		Work Phone
	Other		Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

- ◆ I request this medication to be given as ordered by the licensed health professional (i.e.: doctor)
 - ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand that any **oral** medication will not necessarily be given by a school nurse (but **only** by trained and supervised school staff).
 - ◆ I release school staff from any liability in the administration of this medication at school.
 - ◆ Medication information may be shared with school staff working with your child and 911 staff, if they are called.
 - ◆ All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.
- ☞ I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No

Parent/Guardian Signature Date

School Nurse Signature Date

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.