Date Plan was Developed: ______________________________ **School Nurse #** ______________________________

COLTON SCHOOL DISTRICT

SEVERE FOOD ALLERGY

LICENSED HEALTH PROFESSIONAL (LHP) ORDERS / CARE PLAN

(Must be completed legibly by a licensed health professional)

NAME			**Severe ALLERGY to**
Student should avoid contact with this/these allergen(s)			**Other allergies:**
School	**Birthdate**	**Grade**	**Routine medications (at home/school)**
Bus #	**Car** ☐	**Walk** ☐	
Asthmatic? (High risk for severe reaction): ☐ Yes ☐ 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 food, immediately determine the symptoms and treat the reaction as follows:

Symptoms (known symptoms 'X')		**Give Medication (X)**	
☐ MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth	☐ Antihistamine	☐ Epipen
☐ SKIN	Hives, itchy rash, and/or swelling about the face or extremities	☐ Antihistamine	☐ Epipen
☐ THROAT	Sense of tightness in the throat, hoarseness and hacking cough	☐ Antihistamine	☐ Epipen
☐ GUT	Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea	☐ Antihistamine	☐ Epipen
☐ LUNG	Shortness of breath, repetitive coughing, and/or wheezing	☐ Antihistamine	☐ Epipen
☐ HEART	"Thready" pulse, "passing out", fainting, blueness, pale	☐ Antihistamine	☐ Epipen
☐ GENERAL	Panic, sudden fatigue, chills, fear of impeding doom	☐ Antihistamine	☐ Epipen
☐ OTHER	______________________________	☐ Antihistamine	☐ Epipen
◆ If a **food allergen** has been ingested, but no symptoms: Other: ______________		☐ Antihistamine	☐ Epipen
◆ If exposure to allergen other than by ingestion (i.e., skin, inhalation)		☐ Antihistamine	☐ Epipen
◆ If a reaction is progressing (several of the above areas affected)		☐ Antihistamine	☐ Epipen

- **Asthma?** ☐ Yes ☐ No
- If **only** lung symptoms are present without known triggers of asthma or suspected ingestion first give: ☐ Fast acting inhaler ☐ Antihistamine ☐ Epipen
- If only inhaler is given and lung symptoms are not relieved within ______ minutes ☐ Repeat inhaler ☐ Antihistamine ☐ Epipen

Medication Doses		
Antihistamine ________________ cc/mg		Give: ______ Teaspoons ______ Tablets by mouth Side Effects:
Epipen (.03) ☐	Epipen Jr. (0.15) ☐	Side Effects:
Repeat dose of Epipen: ☐ Yes ☐ 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

- This student is allowed to eat only the following foods:______________________________

☐ Those in manufacturer's packaging with ingredients listed and determined allergen-free by the nurse/parent or ____

☐ Those approved by parent.

☐ Middle school or high school student will be making his/her own decision.

☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.

☐ Parent/guardian should be advised of any planned parties as early as possible.

☐ 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 ☐ NO Restrictions

☐ Student will sit at a specified allergy table.

☐ Student will sit at the classroom table cleansed according to procedure guidelines prior to student's arrival and following student's departure.

☐ Student will sit at the classroom table at a specified location.

- Cafeteria manager and hostess should be alerted to the student's allergy.
- Other ____

EMERGENCY CONTACTS

Mother/Guardian	
Name	
Home Phone	
Work Phone	
Other	

Father/Guardian	
Name	
Home Phone	
Work Phone	
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.