Maryville R-II School District

Life-Threatening Allergy Care Plan

Place student picture here

NAME:	Severe ALLERGY to:
	Other Allergies:
Please list the specific symptoms the student has experienced in the past:	Asthma? ☐ Yes (High risk for severe reaction) ☐ No

School:	Date of Birth:	Grade:	Routine medications (at home/school):
Bus #	Car ☐	Walk ☐	Date of last reaction:

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

☐ **Office** ☐ **Backpack** ☐ **On Person** ☐ **Coach** ☐ **Other**__________ ☐ **Nurses Office**

<u>Allergy Symptoms</u>: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

MEDICATION ORDERS

Epi-pen® (0.3) ☐ Epi-pen Jr.® (0.15) ☐ Other ☐	Side Effects:
Repeat dose of medication ordered: ☐ Yes ☐ No	If Yes, when
Antihistamine Dose:	Give: ____ Teaspoons ____ Tablets by mouth Side Effects:

- It is medically necessary for this student to carry emergency medication during school hours. ☐ Yes ☐ No
- Student may self-administer emergency medication as ordered. ☐ Yes ☐ No
- Student has demonstrated use to Licensed Healthcare Provider. ☐ Yes ☐ No

Licensed Health Care Provider's Signature:	Date:
Licensed Health Care Provider's Printed Name:	Phone: Fax Number:

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
  - **NOTE TIME________AM/PM (Epi-pen®/epinephrine given)** • **NOTE TIME________AM/PM (Antihistamine given)**
- **CALL 911 IMMEDIATELY. <u>911 must be called WHENEVER Epi-pen®/epinephrine is administered.</u>**
- **DO NOT HESITATE to administer Epi-pen®/epinephrine and to call 911 even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and Epi-pen®/epinephrine is being administered.
- An adult trained in CPR is to stay with student–monitor and begin CPR if necessary.
- Call the School Nurse or Health Services Main Office at__________.
  - Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
  - Notify the administrator and parent/guardian.
  - Dispose of used Epi-pen®/syringe in "sharps" container or give to EMS along with a copy of the Emergency Action Plan.

Individual Considerations

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

- This student carries Epi-pen®/epinephrine on the bus: ☐ Yes ☐ No
- Epi-pen®/epinephrine 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 – Epi-pen®/epinephrine and EAP should accompany student during any off campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: ☐ Yes ☐ No
- Staff trained in Epi-pen®/epinephrine use must accompany the student on a field trip.
- Other (specify) ____________________

CLASSROOM – For Food allergy only

- Student is allowed to eat only the following foods: ____________________

☐ Those in manufacturer's packaging with ingredients listed and determined allergen-safe by the nurse/parent or ____________________
☐ Those approved by parent.
☐ High school student will be making his/her own decision.
☐ Alternative snacks will be provided by parent/guardian.
☐ Parent/guardian should be advised of any planned parties as early as possible.
☐ Classroom projects should be reviewed by the teaching staff and approved by building administrator 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

1.	Relationship:	Home Ph:	Work Ph:	Cell Ph:
2.	Relationship:	Home Ph:	Work Ph:	Cell Ph:
3.	Relationship:	Home Ph:	Work Ph:	Cell Ph:
4.	Relationship:	Home Ph:	Work Ph:	Cell Ph:

- I request this medication to be given as ordered by the school nurse or designee.
- I give trained school district staff permission to communicate with the medical office about this medication.
- Medical/Medication information may be shared with school staff working *directly* with my 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 care provider.
- I request and authorize my child to carry and/or self-administer their medication. Yes ______ No_____
- I understand the permission to possess and self-administer an Epi-pen®/epinephrine may be revoked by the principal/school nurse if it is determined that my child is not safely and effectively able to self-administer.

____

Parent/Guardian Signature Date

Student demonstrated to the nurse the skill necessary to self-administer the medication.

Device(s) if any, used: ____________________ Expiration date(s): ____________________

____

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 directly involved with the student.

MARYVILLE R-II SCHOOL DISTRICT
PARENTAL PERMISSION FOR
STUDENT MEDICATION ADMINISTRATION

The Maryville R-II School District's Medication Policy requires written parental/guardian consent prior to giving any prescription or over-the-counter medications at school. This form is to be completed for each medication given. **Medication is to be supplied in the original container with only a 30 day supply each time brought by a parent/guardian or other responsible adult. A new written medical provider order must be presented for any medication changes.**

If the medication is a prescription, ask your pharmacist to prepare two labeled containers, one to be kept at school and one for home. **THE VERY FIRST DOSE OF MEDICATION WILL NOT BE GIVEN AT SCHOOL.**

Student Name____Grade____________

Name/Dosage of Medication____

Time to be Taken ____

Form of Medication/Treatment ____Tablet/Capsule ____Liquid ____Inhaler ____Other

Reason for Medication____

Physician's Name____

Medication to be Given From___________________TO____________________________
(Start Date) (End Date)

When was First Dose of Medication Given? ____

List Student's allergies____

I request the above medication or treatment be administered to my child at school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school nurse immediately if any information provided on this form changes. I give permission for the school nurse to communicate with the above physician or medical provider regarding any questions or concerns about the above medication or treatment. I also agree to pick up any remaining medication within one day after the last day of school or the school will dispose of the medication.

____ _____________________
Parent/Guardian Signature Date

MARYVILLE R-II SCHOOL DISTRICT
AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION AT SCHOOL OR AFTER-SCHOOL ACTIVITIES

In accordance with School Board policy JHCD, a student may carry and self-administer medication for the treatment of Asthma, Anaphylaxis, or Diabetes on district property, at district-sponsored activities, and in transit to and from school or activities in accordance with law. The district will not allow any student to self-administer medications unless:

1. The medication is prescribed by the student's physician and is in original container with directions for use.
2. The physician has provided a written treatment plan for the condition for which the medication is prescribed and certifies that the student is capable and responsible in use of the medication. The student must demonstrate to the physician or physician's designee the skill necessary to use the medication.
3. The student has demonstrated proper self-administration technique to school nurse.
4. The student's parent/guardian has signed a statement authorizing self-administration of the medication.

Name/Dose of Medication ______________________________

Diagnosis for which medication is needed ______________________________

I authorize the Maryville School District to allow my child to carry and self-administer medication for Asthma, Anaphylaxis, or Diabetes. I acknowledge that the district and its employees or agents will incur no liability as a result of any injury arising from the self-administration of such medication. The school nurse reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior that could pose a safety or health risk.

Student's Name ______________________________ Grade __________

Parent/Guardian Signature ______________________________ Date __________

The above student has been instructed in correct administration of above medication and has demonstrated correct technique. In my opinion, this student shows capability to carry and self-administer the above medication.

Physician Signature ______________________________ Date __________