ARLINGTON
Public Schools

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Life Threatening Allergy Emergency Care Plan

Severe allergy to: ____________________ School year __________

Student legal last name ____________________ First name ____________________ MI ______

Birth date __________ School ____________________ Grade __________ Other ID# __________

Transportation: ☐ Walker ☐ Self Transported ☐ Bus Rider Bus/Route Number __________

Parent/Guardian Information

Parent/Guardian ____________________ Primary phone ____________________

Work phone ____________________ Cell phone ____________________

Parent/Guardian ____________________ Primary phone ____________________

Work phone ____________________ Cell phone ____________________

Physician and Hospital Information

Physician Name ____________________ Phone ____________________

Preferred Hospital ____________________ Phone ____________________

Medical Information

Asthma ☐ Yes (High risk for severe reaction) ☐ No

Please list specific symptoms the student has experienced in the past and provide the date of the last reaction (if no symptom or date, please write "none")

Other Allergies	Specific Symptom	Date of last reaction

ALLERGY SYMPTOMS: 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, stomach ache/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

☐ Epinephrine Auto-Injector (0.3 mg) ☐ Epinephrine Auto-Injector (0.15 mg) Side Effects ____________________

Repeat dose of Epinephrine Auto-Injector ☐ Yes ☐ No If "Yes", when ____________________

Antihistamine Name ____________________ Dose __________ When __________ ☐ Teaspoon ☐ Tablet

It is medically necessary for this student to carry an Epinephrine Auto-Injector during school hours ☐ Yes ☐ No

Student may self-administer Epinephrine Auto-Injector ☐ Yes ☐ No

Student has demonstrated use to Licensed Health Care Professional ☐ Yes ☐ No

Physician Signature ____________________ *****Original signature required! Please print and sign.***** *(This notation will not print.)* Date __________

AN ADULT TRAINED IN CPR IS TO STAY WITH THE STUDENT AT ALL TIMES - Action Plan (Give medication as ordered on Page 1)

☐ Epinephrine Auto-Injector given Time given ____________ ☐ AM ☐ PM

☐ Antihistamine given Time given ____________ ☐ AM ☐ PM

CALL 911 IMMEDIATELY

911 must be called WHENEVER an Epinephrine Auto-Injector is administered.
DO NOT HESITATE to administer Epinephrine Auto-Injector and call 911, even if parents/guardians cannot be reached.
Advise 911 if the student is having a severe allergic reaction and an Epinephrine Auto-Injector is being administered.
An adult trained in CPR is to monitor the student (and begin CPR if necessary) until EMS arrives.
Call the School Nurse or the Health Services Main Office - Nurse's phone number:____________
Notify building Administrator and Parent/Guardian.
Dispose of used Epinephrine Auto-Injector in the "sharps" container or give to EMS responders.
Have a copy of Care Plan for EMS responders.

INDIVIDUAL CONSIDERATIONS - TRANPORTATION/BUS

Transportation should be alerted to the student's allergy? ☐ Yes ☐ No
Student carries an Epinephrine Auto-Injector on the bus ☐ Yes ☐ No
An Epinephrine Auto-Injector can also be found in: ☐ Backpack ☐ Waist pack ☐ On student ☐ Other: ____________
Student will sit at the front of the bus ☐ Yes ☐ No
Other instructions: ____________

INDIVIDUAL CONSIDERATIONS - OFF CAMPUS ACTIVITIES/FIELD TRIPS

Epinephrine Auto-Injector should accompany the student during any off campus activities.
Student should remain with the teacher or parent/guardian during the entire field trip ☐ Yes ☐ No
Staff members on trip must be trained regarding Epinephrine Auto-Injector use, understand and have a copy of the student's health care plan.
Other instructions: ____________

INDIVIDUAL CONSIDERATIONS - CLASSROOM - FOR FOOD ALLERGIES ONLY

Student is not allowed to eat the following foods:

Foods in manufacturer's packaging with ingredients listed & determined to be allergen-safe by the school nurse, parent/guardian:

Foods approved by parent/guardian:

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

Other instructions: ____________

INDIVIDUAL CONSIDERATIONS - CAFETERIA

☐ No Restrictions
☐ Student will sit at a specified allergy table

The Cafeteria Manager and/or hostess should be alerted to the student's allergy? ☐ Yes ☐ No

Other instructions:

Classroom Accommodations - Modifications
Report concerns to parent/guardian for physician follow-up

Emergency Contacts

Name ______________________ Phone ______________ Relationship ______________

Name ______________________ Phone ______________ Relationship ______________

Name ______________________ Phone ______________ Relationship ______________

- ☐ I request this medication to be given as ordered by the licensed health care provider.
- ☐ I give Health Services Staff permission to communicate with the medical office about this medication.
- ☐ I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised)
- ☐ 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

This permission to possess and self-administer a Epinephrine Auto-Injector may be revoked by the principal or school nurse if it is determined that your child is not safely and effectively able to self administer.

Parent/Guardian Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* ______________________ Date ______________

School Nurse Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* ______________________ Date ______________

Physician Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* ______________________ Date ______________

A copy of this plan will be kept in the school office and copies will be given to:

☐ Para educator ☐ Transportation ☐ Teacher ☐ PE Teacher ☐ Student Services ☐ Health Room ☐ Secretary-Principal

Other ____

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING