Holly Area Schools

Severe Allergy Medical Care Plan

*This care plan is valid for **one school calendar year** and must be update by the prescribing physician if any changes are made during the school year*

Student's Name: _____ School Year :_____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

ALLERGY: (Check appropriate box and list specific allergen)

☐ Foods: ☐ Peanut ☐ Tree Nut Other: _____

☐ Latex

☐ Stinging Insects: _____

☐ Other: _____

History of Asthma: ☐ Yes ☐ No

If your child needs medication at school for asthma, please complete a **separate** Asthma Care Plan.

Contact Information

First Contact	**Second Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____
Phone (2): _____	Phone (2): _ _____

☐ YES ☐ NO I would like to talk with the school nurse regarding my child's allergies.
☐ YES ☐ NO My child is to self-carry their own medication. (A self carry form **must** be signed to self-carry)
☐ YES ☐ NO If my child is to self-carry epinephrine, I will still supply the school with a back up auto-injector.

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician or licensed prescriber.
Without **both** signatures this care plan is not valid. The parent/guardian is responsible for supplying none expired medication.

I certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of medications at school. I agree to have the information within this medical care plan shared with staff, as needed. I give permission for Holly Area Schools (HAS) staff to give the medication(s) as ordered on this care plan for allergic reactions. I give my permission for staff to contact the physician/licensed prescriber for clarification of these orders, if needed. I will not hold HAS Board of Education or its personnel, or employees responsible for complications related to the medication or treatment/care administered pursuant to this plan.

_____ _____
Parent Signature **Date**

5/2024 **Office Use:** Skyward Alert: ___ Email: ___ Food service: _____ Date: _____ Initials: _____

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Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

Student Name: _____ Date of Birth: _____ School Year: _____

Mild Symptoms

- Give Antihistamine-If prescribed (see below)
- Call parent/guardian & district nurse
- If Symptoms progress: **USE EPINEPHRINE** (see below)

Monitoring

Stay with Student & remain calm
Provide reassurance
Monitor for worsening symptoms

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following (any combination):
Lung: Short of breath, wheezing, repetitive cough
Heart: Pale, faint/weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Tongue or lips swelling, blue around lips, metal taste
Skin: Multiple hives on body, itchy, swelling of an area or face
Gut: Vomiting, cramping like pain, diarrhea
Mental: Anxiety, confusion, sense of impending doom

* If a student is to self-carry epinephrine, help may still be needed to give the medication.

Inject Epinephrine Immediately!
Call 911, then parent/guardian & nurse
Give additional medication* (if ordered)
(Antihistamine or inhaler)
Tell rescue staff that epinephrine was given & time administered. What the suspected allergen was. (**If** having trouble breathing- allow student to sit up). Have student lay down with feet elevated. Roll to side if vomiting. Treat student even if parents cannot be reached.
***2nd dose** may be given if symptoms worsen and help has not arrived.
Start CPR, if necessary.

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

☐ If checked, give epinephrine **immediately** if **ANY** symptoms are present, if allergen was **likely** eaten.

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

Epinephrine IM (intramuscular) dose: ☐ .15 (junior) ☐ .3 (adult)

Authorization for **student to self carry: ☐ Yes ☐ No** - The student has been instructed on how to use the epinephrine injector correctly, knows when to get assistance and not to share their medication. Therefore it is my professional opinion the student should be allowed to self-carry their own epinephrine.

Antihistamine Name: _____ **Dosage:** _____ **Route:** _____

Should antihistamine be administered before Epinephrine, if mild symptoms present? ☐ Yes ☐ No

Please list parameters for antihistamine use: _____

Other Medication: _____ Dosage: _____ Route: _____
Please list parameters for usage of medication: _____

Other instructions or orders: _____

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____