Date Plan Developed/Revised:
2015-2016 school year

OUR LADY OF MERCY SCHOOL
LIFE THREATENING ALLERGY

Place student picture here

LICENSED HEALTH PROFESSIONAL (LHP) ORDERS / CARE PLAN
(Must be completed legibly by a licensed health professional)

NAME **TEACHER**			**Severe ALLERGY to** **Other Allergies:**
School **Our Lady of Mercy School**	**Birth date**	**Grade**	**Routine medications** (at home/school)
Bus #	**Extending Day** ☐	**Private transportation** ☐	**Date of last reaction:**

Please list the specific symptoms the student has experienced in the past:

Location(s) where Epi-pen®/Rescue medications is/are stored:
☐ **Nurse's Office** ☐ **Classroom** ☐ **Cafeteria** ☐ **Other**_____

EMERGENCY CARE 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')

☐ 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 impeding doom
☐ OTHER	_____

- **Asthma?** ☐ Yes (High risk for severe reaction.) ☐ No
- If **only** lung symptoms are present without suspected ingestion first give:

☐ Fast acting inhaler _____ ☐ Antihistamine ☐ Epi-pen®

- If only inhaler is given and lung symptoms are not relieved within _____ minutes

☐ Repeat inhaler ☐ Antihistamine ☐ Epi-pen®

Medication Doses

Epipen ® (0.3) ☐ Epipen Jr.® (0.15) ☐	Side Effects:
Repeat dose of Epipen®: ☐ Yes ☐ No	If YES, when
Antihistamine _____ cc/mg	Give: _____ Teaspoons _____ Tablets by mouth Side Effects:

- **GIVE MEDICATION AS ORDERED ABOVE & AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
  - **NOTE TIME**_____**AM/PM (Epi-pen®/adrenaline given)** • **NOTE TIME**_____**AM/PM (Antihistamine given)**
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epi-pen® is administered.**
- **DO NOT HESITATE to administer Epi-pen® and to call 911 even if the parents cannot be reached.**
- Advise 911 that the student is having a severe allergic reaction and Epi-pen® is being administered.
- An adult trained in CPR is to stay with student –monitor and begin CPR as 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® in "sharps" container or give to EMS along with a copy of the Emergency Care Plan

	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

Field Trip Procedures – Epi-pen® 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 Epi-pen® use and this health care plan (plan must be taken).
- Other (specify) _____

CLASSROOM --For Food allergy only

- 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.

☐ 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		Father/Guardian	
	Name		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 the medication/s will not necessarily be given by a school nurse (but also by trained and supervised school staff).
- I release school staff from any liability in the administration of this medication at school.
- Medical/Medication information may be shared with school staff working 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 professional.

Parent/Guardian 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

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

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

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

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

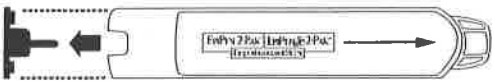
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

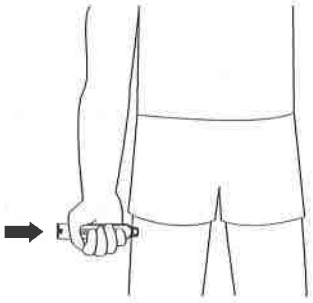
Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**



- **Hold orange tip near outer thigh (always apply to thigh)**



- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

BEE STING ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Severity of reaction(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is give immediately.

Student Photo

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

Benadryl ordered: ❑ Yes ❑ No Give _____ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ❑ Yes ❑ No Special instructions: _____

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ❑ Medication available on bus ❑ Medication NOT available on bus ❑ Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed.

Revised 1/08

Our Lady of Mercy School
55 Fourth Avenue, East Greenwich, Rhode Island 02818
Phone: (401) 884-1618 / Fax: (401) 885-3138
Website: www.olmschool.org

Permission to Administer Medication

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____

To Be Completed By Health Care Provider

Diagnosis _____

Medication _____ Dose _____ Route _____ Time(s) _____

Medication _____ Dose _____ Route _____ Time(s) _____

Medication _____ Dose _____ Route _____ Time(s) _____

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ Date _____ Phone _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature _____ Date _____ Phone _____

School Nurse: _____ School _____

Phone: _____ Fax: _____ Email _____