Individualized Health Care Plan - Severe Allergy

Student Name
Allergy

Any SEVERE SYMPTOMS
after suspected or known ingestion:

One or more of the following:
LUNG: Short of breath, wheezing, 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, crampy pain

1. GIVE _____

2. 911
3. Alert School Nurse and Parent
4. Begin monitoring (see box below)
5. Give additional medications as ordered:

_____

_____

MILD SYMPTOMS ONLY:
MOUTH: Itchy Mouth
SKIN: A few hives around mouth/face, itch
GUT: Mild nausea/discomfort

1. GIVE _____

2. Stay with student; alert School Nurse and Parent.
3. If symptoms progress (see RED box above)
4. Begin monitoring (see box below)

☐ **If checked, give epinephrine immediately even if NO SYMPTOMS and exposed to the allergen**

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 five 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.

Foods to Avoid

specific to student

Individual notes:

specific to student

Symptoms experienced in the past:

specific to student

Parent Signature _____ Physician Signature _____

Date _____ Date _____

See Back for Physician Medication Order

Anthony Wayne Local Schools

Medication for Anaphylaxis (Severe Allergy)

Student Information

Student Name		Date of birth
Address		
Weight	**Asthma:** ☐ **YES (Higher risk for a severe reaction)** ☐ No	
Allergies:		

Prescriber Authorization

Epinephrine (brand and dose):	
Antihistamine (brand and dose):	
Other (e.g., inhaler-bronchodilator if asthmatic):	
Date to begin medication	Date to end medication
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief	
Special Instructions	
Authorization is hereby given for the student named above to (please ☑)	
☐ **As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.**	
☐ **Receive the prescribed medication indicated from the designated school personnel.**	
Prescriber signature	Date
Prescriber name	
Phone	Fax

Parent/Guardian Authorization

☑ I understand that according to Anthony Wayne Board of Education Policy 5330 (Use of Medication) this form must be completed by the prescribing physician and parent prior to administration of prescription medication by designated school personnel. ☑ I authorize a designated employee of the Anthony Wayne Board of Education to administer the above medication. ☑ I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. ☑ I understand that additional parent/prescriber statements will be necessary if the dosage or time or interval of the medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. ☑ I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration. ☑ **I understand that Ohio law requires a "back-up" epinephrine autoinjector is available at the designated school health clinic or office for emergencies.** {ORC 3313.718(3)}

Parent must ☑ below to indicate student is allowed to self-carry their epinephrine autoinjector	
☐ **I authorize self-medication by my child for the prescribed listed medication.**	
☐ **I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician.**	
Parent/Guardian Signature	Date
#1 Contact phone	#2 Contact phone

School Personnel Only	Location #1	Location #2	Expiration	School Nurse/School personnel signature
Epinephrine				
Antihistamine				
Inhaler				Date