**QUINCY PUBLIC SCHOOL DISTRICT 172**
**ALLERGY MEDICAL MANAGEMENT PLAN**

**PART I** **TO BE COMPLETED BY PARENT**

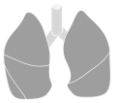
**Student**_____ **ID #** _____ **D.O.B.** _____ **School** _____

**ALLERGY TO** _____ **Teacher/Grade** _____

**Asthmatic** ☐**Yes*** ☐**No** ***Higher risk for Severe Reaction**

**PART II** **TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER**

## FOR **ANY** OF THE FOLLOWING **SEVERE** SYMPTOMS:



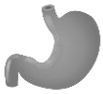
**Lung**
Shortness of Breath, wheezing repetitive cough

**Heart**
Pale or bluish skin, faintness, weak pulse, dizziness

**Throat**
Tight or hoarse throat, trouble breathing or swallowing

**Mouth**
Significant swelling of the tongue or lips

**Skin**
Many hives over Body, widespread redness



**Gut**
Repetitive vomiting, severe diarrhea

**Other**
Feeling something bad is about to happen, anxiety, confusion

**Or a Combination**
of symptoms from different body areas

1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

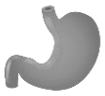
- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## **MILD** SYMPTOMS

**Nose**
Itchy or Runny nose Sneezing

**Mouth**
Itchy Mouth

**Skin**
A few hives mild itch



**Gut**
Mild nausea or discomfort

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FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE

FOR **MILD** SYMPTOMS FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

**Epinephrine Dose:**
☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

**Student May Self Carry** ☐ **Yes** ☐ **No**

**Antihistamine**_____
Dose/Frequency: _____

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

I request designated staff to administer the medication as prescribed by the licensed provider above. I certify that I have legal authority to consent to the administration of medication at school. I authorize the school nurse to communicate with the licensed prescriber regarding the administration of this medication.

_____ _____ _____
**Parent/Guardian Signature** **Telephone** **Date**

_____ _____ _____ _____
**Licensed Health Care Provider** **Licensed Health Care Provider** **Telephone** **Date**
**Print** **Signature**

**PART III** **TO BE COMPLETED BY PARENT**

## History and Current Status

1. How many times has student had a reaction? ☐ Never ☐Once, Age ___ ☐ More than once, explain: _____
2. Explain their past reaction: _____
3. Symptoms: _____
4. What are the **early** signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say) _____ _____

## Treatment

1. Has your student previously used treatment or medication for their allergy? ☐ No ☐ Yes, Age _____ Treatment/medication used _____
2. How effective was the student's response to previous treatment? _____
3. Was there an emergency room visit? ☐ No ☐ Yes, explain _____
4. Was the student admitted to the hospital? ☐ No ☐ Yes, explain _____
5. Please describe any side effects or problems your child had in using the suggested treatment: _____

## Self Care

1. Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes
2. Does your student:
   a. Know what foods to avoid ☐ No ☐ Yes
   b. Ask about food ingredients ☐ No ☐ Yes
   c. Read and understand food labels ☐ No ☐ Yes
   d. Tell an adult immediately after an exposure ☐ No ☐ Yes
   e. Wear a medical alert bracelet, necklace, watchband ☐ No ☐ Yes
   f. Tell peers and adults about the allergy ☐ No ☐ Yes
   g. Firmly refuses a problem food ☐ No ☐ Yes
3. Does your child know how to use emergency medication? ☐ No ☐ Yes
4. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

Explain any of the above: _____

## Parental Permission for Student to Self-Carry Epinephrine ☐ No ☐ Yes

If yes, I hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize the School District to allow my child to self-administer his or her lawfully prescribed Asthma Inhaler/Epinephrine medication during the following: (1) while in school; (2) while at a school-sponsored activity; (3) while under the supervision of school personnel; and (4) before or after normal school activities.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma medication. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self-administration of said medication.

_____ _____

**Parent/Guardian Signature** **Date**

**QUINCY PUBLIC SCHOOL DISTRICT 172**
**ALLERGY ACTION PLAN**

| **PART III** | **TO BE COMPLETED BY SCHOOL NURSE** |
|---|---|

**Student** _____ **ALLERGY** _____

## ACTION PLAN CHECKLIST FOR SCHOOL PERSONNEL

- Allergy Action Plan Part I and II, complete □ **yes** □ **no**
- Antihistamine medication authorization complete □ **yes** □ **no**
- Epinephrine medication authorization complete □ **yes** □ **no**
- Medication self carried □ **yes** □ **no**

- Medication stored:_____(Location),_____(Location)
- Expiration date of medication (s):_____(Epinephrine),_____(Antihistamine)

- Copies of plan provided to: Educational □ **yes** □ **no** □ **n/a**
  Athletic □ **yes** □ **no** □ **n/a**
- Notify of specific allergy: Food Service □ **yes** □ **no** □ **n/a**
- Staff trained in medication Administration □ **yes** □ **no**

| **PART IV** | **TRAINED STAFF IN ADDITION TO SCHOOL NURSE** |
|---|---|

Name_____ Date_____ Location_____

Name_____ Date_____ Location_____

The EpiPen is self-injecting. It is used in cases of anaphylaxis of any cause.

Directions for use:

- Remove gray safety cap and grasp EpiPen with your fist
- Press the black end of EpiPen against outer thigh until you hear a click and needle is released. EpiPen is designed to be used through clothing if necessary.
- **Maintain EpiPen in position for 10 seconds.**
- Remove EpiPen, call 911 for immediate medical attention
- Carefully place the used auto-injector (without bending the needle), needle-end first, into the storage tube of the carrying case that provides built-in needle protection after use. Then screw the cap of the stored tube back on completely and give to the emergency responder to dispose of in the emergency room.

**Full Allergy Action plan has been reviewed.**

_____ _____

**School Nurse** **Date**

Adapted from: Virginia Department of Health, Virginia Department of Education (2004) *Guidelines for Specialized Health Care Procedures* and from the Office of Catholic Schools Diocese of Arlington