Boyertown Area School District Allergy and Anaphylaxis Emergency Care Plan

Student's Name_____ DOB _____Grade/Homeroom____

Has a life-threatening or severe allergy to:

	INGESTION	INHALATION	SKIN/ CONTACT	INSECT BITE
_____	□	□	□	□
_____	□	□	□	□
_____	□	□	□	□
_____	□	□	□	□

SYMPMTOMS

Provide treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

□ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea

□ Respiratory: shortness of breath, repetitive coughing, wheezing

□ Heart: pale, blue, "thread" pulse, dizziness or fainting

□ General: panic, sudden fatigue, chills, fear of impending doom

□ Skin: hives, itchy rash, swelling about face or extremities

□ Other:_____ _____

□ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth

□ Throat: feeling tightness in the throat, hoarseness, hacking cough

HISTORY:

Date of last reaction that required medication: _____

SCHOOL EMERGENCY PLAN: *Please instruct your child to tell an adult and or a nurse if they develop signs and symptoms of a severe allergic reaction while under school jurisdiction.*

1. Mild Reaction (Hives only)
   Medication_____Dose_____Frequency_____

2. Severe Reaction: any or a combination of symptoms;

   Medication_____Dose_____Frequency_____
   Medication_____Dose_____Fequency_____

INJECT EPINEPRINE IMMEDIATLEY/ CALL 911

[ ] If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

[ ] If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

___* I believe this child has demonstrated the skills or responsibility to carry and self- administer their Epi-pen during the regular school day, on field trips, and at extra-curricular activities upon clearance by their physician, parent, and nurse. *Your initials indicate that the child is capable of proper medication administration.

___** I believe this child is able and responsible to carry and self-administer the medication on certain field trips and at extra-curricular activities. S/he has permission to do so and has been instructed on how to self-administer (Gr.6-12 only). **Your initials indicate that the child is capable of proper medication administration.

PHYSICIAN's SIGNATURE_____DATE_____

3. Notify Parent or guardian:
   *Name/Relationship_____Phone_____
   *Name/Relationship_____Phone_____

A Parent/ guardian signature is required: Please complete the back side of this Action Plan

I, the parent/guardian of _____ request that the Boyertown Area School District nurse administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Boyertown Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the prescribed medication.

Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

____* I believe my child is able and responsible to carry and self-administer his/her Epi-pen during the regular school, on field trips, and at extra-curricular activities (Grades K-12) I give my permission for him/her to do so (Gr. K-12). *Your initials indicate that the child is capable of proper medication administration.

____** I believe my child is able and responsible to carry and self-administer his/her medication on certain field trips and at extra-curricular activities. I give my permission for him/her to do so (Gr.6-12). **Your initials indicate that the child is capable of proper medication administration.

PARENT /GUARDIAN SIGNATURE_____DATE_____

I give permission for the release and exchange of information between the nursing staff and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

DATE_____PARENT/GUARDAN SIGNATURE_____

***REMINDER: All Action Plans and Medications require a yearly renewal while your child is under School Jurisdiction.**

Individualized Health Plan for Anaphylaxis

Assessment: Student has documented an allergic reaction causing severe reaction or anaphylaxis with exposure.

Nursing Diagnosis: Ineffective breathing pattern R/T: Bronchospasm Inflammation. Decreased cardiac output related to: hypotensive shock or vascular collapse. Effective therapeutic regimen management related to: inability to develop and implement IHP and ECP, ability to seek help from others, ability to self-medicate when appropriate.

Goal: Student will identify symptoms of allergic reaction. The student will be safe in all school environments. The student will participate in development and implementation of health care plans at school.

Nursing Interventions: Develop and implement Emergency Care Plan with parent approval. Provide health counseling opportunities for student to review symptoms of reaction and to avoid triggers. Inform appropriate school personnel on signs and symptoms of anaphylaxis. Notify cafeteria of all students with food allergies. If a student has a food allergy, have parent provide alternative treats for the classroom. Provide alternate seating in cafeteria for students with food allergies. If student exposed to allergen follow Emergency Care Plan for treatment of symptoms. Administer physician prescribed medication in compliance with the BASD medication policy. Complete self-administration checklist, if age appropriate.

Expected Outcomes: The student will identify his or her symptoms of an allergic reaction and share information with appropriate school personnel. The student will actively participate in health care management and ECP at school. The student will have medication available as ordered by physician. The student will demonstrate proper technique of self-medicating, if deemed appropriate by parent and prescribing physician. Self-administer checklist will be completed.