Community Colleges of Spokane

Spokane County Head Start/EHS
SEVERE ALLERGIC REACTION PLAN & MEDICATION ORDERS

Attach Child's picture here

Nurse Consultant phone #: _____ **Child has severe allergy to:** _____

Date Plan Developed/Revised/Reviewed: _____

NAME:	**Birthdate:**
Site Room/FSC	
Allergy History: ☐ History of anaphylaxis/severe reaction ☐ Skin testing indicates allergy Date of Last Reaction:	
Other Allergies:	☐ **Child has Asthma** (increased risk factor for severe reaction)

Anaphylaxis (Severe allergic reaction) is an excessive reaction by the body to combat a foreign substance that has been eaten, injected, inhaled absorbed through the skin. It is an intense and life-threatening medical emergency. **Do not hesitate to give Epi auto-injector and call 911.**

USUAL SYMPTOMS of an allergic reaction:

MOUTH--Itching, tingling, or swelling of the lips, tongue, or mouth
THROAT--Sense of tightness in the throat, hoarseness and hacking cough
LUNG--Shortness of breath, repetitive coughing, and/or wheezing
GENERAL--Panic, sudden fatigue, chills, fear of impending doom
SKIN--Hives, itchy rash, and/or swelling about the face or extremities
GUT--Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea
HEART --"Thready" pulse, "passing out", fainting, blueness, pale

This Section To Be Completed By A Licensed Healthcare Provider (LHP):

If a child has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to something allergic to):

1. **Give** Epi auto-injector ☐ 0.3 mg ☐ Jr. 0.15 mg
   ☐ **May repeat Epi auto-injector (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived.**
   Document time medications were given below and alert EMS when they arrive.

_____	_____	_____	_____
Epi-pen #1	Epi-pen #2	Antihistamine	Inhaler

2. **Stay with child.**
3. **CALL 911 – Advise EMS that child has been given Epinephrine**
4. **Notify parents and Health Services Specialist and Nurse Consultant.**
5. **After Epi auto-injection given, give Benadryl® or antihistamine _____ (ml/mg/cc)**
6. **If child has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction, after Epi auto-injection and antihistamine, may give:**
   ☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) ☐ Albuterol/Levalbuterol unit dose SVN (per nebulizer)
   ☐ Levalbuterol 2 puffs (Xopenex®) ☐ Other _____
7. **A child given an Epi auto-injector must be monitored by medical personnel or a parent & may NOT remain at school**

SIDE EFFECTS of medication(s):

Epi auto-injector: _____ _____

Albuterol/Levalbuterol: _____

PLEASE COMPLETE THIS SECTION IF THE CHILD HAS A SEVERE FOOD ALLERGY – (required by USDA Food Guidelines)

☐ **Check here if child will EAT school provided meals during the entire school year. Parent/Guardian may need to fill out the form *Special Diet Request: Food Allergy / Intolerance*.**

Foods to omit: _____

Suggested general substitutions: _____

See attached form – please complete and sign.

LHP Signature:	Print Name:	
Start date:	End date (not to exceed current school year): ☐ Last day of school ☐ Other:	
Date:	Telephone #:	Fax #:

Child _____

Care Plan for Severe Allergy – Part 2 – Parent Section

Brief Medical History _____

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
- Parent/Guardian should be notified of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- Child is responsible for making his/her own food decision. ☐ Yes ☐ No
- Other _____

Field Trip Procedures – Epi auto-injector must accompany child during any off campus activities.

- Staff members on trip must be trained regarding Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify):

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 (LHP) (i.e., doctor, nurse practitioner, PAC).
- I give HS/EHS staff permission to communicate with the LHP/medical office staff about this plan and medication.
- I understand that any medication will not be given by a nurse but will be given by trained HS/EHS staff.
- I release HS/EHS staff from any liability in the administration of this medication at school.
- Medical/medication information may be shared with HS/EHS 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.
- Child is encouraged to wear a medical ID bracelet identifying the medical condition.

Parent/Guardian Signature _____ **Date** _____