NAZARETH AREA SCHOOL NURSES

(The fax goes directly to the nurses office)

HS fax 610-849-0863 **MS fax** 610-759-3262 **Intermediate fax** 484-292-1113
Bushkill ES fax 610-849-0866 **Lower Nazareth ES fax** 610-849-0865 **Shafer ES fax** 610-849-0862

Anaphylactic Allergy action plan and dietary needs plan *Revised April 2015*

_____

Student's name **Grade** **Date of birth**

Extremely reactive to the following: _____

☐ If checked give Epinpherine immediately for ANY symptoms if the allergen was likely eaten.
☐ If checked give Epinpherine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG Short of breath, wheezing, repetitive cough

HEART Pale, blue, faint, weak pulse, dizzy

THROAT Tight, hoarse, trouble breathing/ swallowing

MOUTH Significant swelling of the tongue and/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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy/runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea/ discomfort

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.

SELF-ADMINISTRATION: for Inhalant, Enzyme or Epinephrine:

The above named student has demonstrated the ability to self-administer the physician-prescribed emergency medication, as indicated by the following criteria:

1. Respond to and visually recognize his/her name.
2. Identify his/her medication.
3. Demonstrate the proper technique for self-administering his/her medication
4. Knowledge of medication side effects and agrees to report any side effects to the Nurse

Do you recommend that the student: Self-administer and carry in school? YES _____ NO _____
Only carry in school? YES _____ NO _____

Medications/Doses:

Epinephrine Brand: Auvi-Q ___ Epi-pen ___ Other: _____ **Dose:** 0.15mg ___ 0.3mg ___

Antihistamine: Benadryl ___ Other: _____ **Dose:** 25mg ___ 50mg ___ Other: _____ **Time:** _____

Inhaler-bronchodilator: _____ **Dose and Time:** _____

_____

Signature of Physician/Psychiatrist/Dentist **Date**

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Anaphylactic Allergy action plan and dietary needs plan

_____

Student's name **Grade** **Date of birth** ***Medication Authorization***

(Physician/Psychiatrist/Dentist and Parent/Guardian)

If your child needs to take medicine in school, prescription or *over-the-counter, the procedure is as follows: The Nazareth Area School District requires a physician's/psychiatrist's/dentist's written order and a parent's/legal guardian's/emancipated student's authorization for the school nurse, or in her/his absence the designee, to administer medications to students in the regular school setting and only in circumstances when the child's health may be jeopardized without it. Written authorization, signed by the physician, psychiatrist, or dentist (original or by fax) and the parent, legal guardian, or emancipated student must be provided for each separate prescription or medication being administered to each student. If dosage is changed, new written authorization is required. Authorization will terminate with the expiration date of the prescription or at the end of the school year, whichever occurs first. If the medication is discontinued, the parent or legal guardian must notify the school nurse in writing. Medication must be delivered to the school nurse by the parent, legal guardian, authorized adult designee or emancipated student in the original medication container. Students are not to have medication in their possession at any time per school district drug and alcohol policy except physician authorized self-administered emergency medications. It will be the responsibility of the parent, legal guardian, or emancipated student to make arrangements for administration of medication during activities away from school. Medication sent to school in violation of this policy will not be administered to a student. **Medication must be in original medication container.**

****See reverse side for medication name, dose, route and frequency***

_____

Physician's name printed

_____

Address

_____

Phone **Fax**

_____

Signature of Physician/Psychiatrist/Dentist **Date**

Authorization by parent/legal guardian/emancipated student

Name of Student _____ is requested to receive the above medication during school hours in order to maintain sufficient health and participation in the school program. We (I) do hereby grant permission for school staff to communicate directly with the physician/psychiatrist/dentist named above. We (I) do hereby release, discharge, and hold harmless NASD, its agents, and employees from any and all liability and claims whatsoever in connection with administration of the above medication to my child. We (I) have read and agree to follow the procedures set forth by the policy and procedure.

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Daytime Phone**

☐ N/A

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose disability restricts their diet and is supported by a statement signed by a licensed physician. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school may choose to accommodate a student with a non-disabling special dietary need that is supported by a statement signed by a recognized medical authority (physician, physician assistant or nurse practitioner).
- The school food authority may choose to make a milk substitution available for students with a non-disabling special dietary need, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations.

Does the student have a disability that requires the student to have a special diet? _____ Yes _____ No
Describe the disability/diagnosis: _____
If student has life threatening allergies, please check when affected: ____ ingestion ____ contact ____ inhalation
If the student is NOT disabled, does he/she have a medically certified special dietary need? _____ Yes _____ No
List Special Diet or Dietary Restrictions: (please be specific regarding foods in their natural form vs. as an ingredient)
_____

Food Allergies or intolerances: (list specific food(s) to be omitted):_____

List Allowable Food Substitutions: _____