Individualized Health Care Plan **Student Name:** **School Year:**

Anaphylaxis (Severe Allergy) Individualized Healthcare Plan

SECTION I			
Student:			WT: / HT:
Grade:	D.O.B	Any Known Allergies	
School:			
District:		Bus (check one) ☐YES ☐NO Bus #AM	Bus #PM
School Nurse:		Pager #	Cell #
Medication taken at home: (please list)			

Contacts

Mother	Home #	Work #	Pager/Cell #
Father	Home #	Work #	Pager/Cell #
Guardian/Custodian	Home #	Work #	Pager/Cell #
Home Address		City #	Zip
Emergency Contact (Relationship)		Home #	Work #
Physician		Phone #	Fax#
Physician Address		City	Zip

Date	Special Notes

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SECTION II: EMERGENCY ACTION PLAN

IF YOU SEE THIS....		DO THIS....
Contact with or ingestion of allergen with no symptoms:		Administer medication? ☐ Yes ☐ No Medication: ________________ Medication dosage: ________________ Call parent or emergency contact. Observe student for ____minutes before return to class. Recheck student in 1 hour.
Symptoms of **MILD** or **EARLY** allergic reaction:	Itching Hives No Respiratory Distress	Administer medication? ☐ Yes ☐ No Medication: ________________ Medication dosage: ________________ Other: ________________ Call parent or emergency contact. Observe student for minutes before return to class.
Symptoms of **SEVERE** allergic reaction:	Mouth, lips or face tingling Feels throat is closing Cough, Wheeze, Stridor **Respiratory distress** Weak pulse, Low BP, Pallor, Sweating Abdominal cramps, Nausea **Loss of Consciousness**	**Call 9-1-1** Administer Epinephrine? ☐Yes ☐ No ☐ Epipen: ☐0.3 mg ☐0.15 mg ☐ Other epinephrine Rx: ☐0.3 mg ☐0.15 mg Other: ________________ Contact Parent/Emergency Contact. Remain with student until EMS personnel arrive. Be prepared to administer second dose of epinephrine, if ordered by prescriber and available.

STEPS FOR ADMINISTERING EPINEPHRINE AUTOINJECTOR:

1. Remove blue safety cap.
2. Place orange tip against lateral thigh (Do NOT touch orange tip)
3. Press orange tip into lateral thigh, through clothing until hear "click"
4. Hold autoinjector in place for count of "10"
5. Pull autoinjector straight away from thigh.
6. Gently massage injection site for 10 seconds.
7. Record date/time administered on autoinjector.
8. Give EMS personnel used autoinjector.

***ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER**

School Nurse Use Only

*Medication	Expiration Date	Self-Carry?	Location of Medication

Notes /Special Instruction________________________________

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SECTION III:

Anaphylaxis is a rare, life-threatening allergy to certain substances such as foods, bee stings, chemicals and medications. It occurs rapidly and can close off the breathing passages. **Exposure to this substance should be avoided, including skin contact, at all times! AVOID EXPOSURE TO FOLLOWING ALLERGEN(S):**

MEDICATION(S) AT SCHOOL:	POTENTIAL SIDE EFFECTS: (Notify school nurse)
◻ Epinephrine Auto-injector: ◻ Carried On-Person? ◻ YES ◻ NO Self-Administer? ◻ YES ◻ NO	Rapid heart rate
◻ Oral Antihistamine (name): Carried On-Person? ◻ YES ◻ NO Self-Administer? ◻ YES ◻ NO	Drowsiness
Other meds at school :	
MEDICATION(S) AT HOME:	**POTENTIAL SIDE EFFECTS: (Notify school nurse)**
CLASSROOM:	**PHYSICAL EDUCATION:**
◻ Inform all parents classroom is "allergy aware" listing all known allergens (sign outside classroom door, newsletters, etc.) ◻ Instruct students to wash hands w/soap & running water before & after meals/snacks ◻ Adult to wipe down tables/desks after meals & snacks, using household cleaning wipe ◻ Avoid learning activities that include allergens ◻ Contact School Nurse immediately if student develops symptoms of severe allergy per Emergency Action Plan on previous page	◻ Avoid contact with balls and other equipment that contain latex ◻ Remain alert for stinging insect nests/mounds & notify Plant Manager immediately if nests discovered. Keep students away from area. ◻ Contact School Nurse immediately if student develops symptoms of severe allergy per Emergency Action Plan on previous page ◻ Other:
Classroom Snacks: (STUDENTS ARE NOT TO SHARE FOOD DURING MEALS OR SNACKS) ◻ Student will bring own snack	◻ Student will select from allergen-free options in classroom supply
FIELD TRIPS:	**BUS TRANSPORTATION:**
◻ Hand wipes to be used before & after meals or snacks if no soap & water available on trip	◻ Driver will wipe down student's assigned bus seat before & after route
If student <u>IS</u> authorized to self-carry and self-administer allergy medications:	If student <u>IS</u> authorized to self-carry and self-administer allergy medications:
◻ Student will keep meds on person at all times ◻ Student will notify teacher immediately if is exposed to allergen &/or develops symptoms ◻ Teacher to assist student as necessary, call 9-1-1 and then contact parent	◻ Student will keep meds on person at all times ◻ Student will notify driver if exposed to allergen &/or develops symptoms ◻ Driver will assist student as necessary and procedure for activating EMS & parent
If student <u>IS NOT</u> authorized to self-carry & self-administer allergy medications:	If student <u>IS NOT</u> authorized to self-carry & self-administer allergy medications:
◻ Nurse or Medication Assistant will accompany trip with medication & orders on person ◻ Student will have ready access to Nurse or Medication Assistant for duration of trip	
EMERGENCY DRILLS AND SCHOOL CRISIS EVENTS:	**OTHER:**
◻ School Nurse will secure medications & orders in accordance with school safety plan ◻ In event of building evacuation, School Nurse or Med Asst will evacuate w/medications & orders ◻ If so authorized, student will keep meds on person for duration of drill or crisis event ◻ Student requires assistance during building evacuation? ◻ NO ◻ YES If "yes", describe:	After School Activity: (Describe)

Huntsville City Schools
Medication Self-Administration Documentation
and/or
Medication Authorized to Keep on Person Documentation

Student Name____ Grade __________

Name of Medication ____ School __________

- ✓ Standardized Medication Authorization is complete with parent and prescriber affirmation signatures authorizing this student to self administer medication and keep his/her medication on person.
- ✓ Students Individual Health Care Plan is complete

_______ Parent/Prescriber Authorization matches prescription label and the label is intact.

_______ Medication is not expired: Product manufacturer expiration date ____________________

_______ Student has knowledge of medication administration and safety, including information addressed in his/her HCP.

_______ Student demonstrates knowledge, skill and experience of his/her chronic illness and medication. He/She verbalizes potential side effects and adverse reactions including when to contact the school nurse or prescriber.

Parent Prescriber Authorization for Self Administration of Medication:

_______ Student agrees he/she is accountable for safe and appropriate self administration of the authorized medication. He/ She has been informed of legal policies and requirements related to self administration of authorized medication and will not give or share medication with another person.

Parent Prescriber Authorization for Medication to Keep on Person:

_______ Student agrees he/she is accountable for safe and appropriate possession of the authorized medication. He/ She has been informed of legal policies and requirements related to possession of authorized medication and will not give or share medication with another person.

Parent/Guardian Signature ____________________________________ **Date:** ______________

Student Signature ____ **Date:** ______________

Parent Prescriber Authorization request that this student be allowed to possess and/or self-administer his/her own medication. I am reasonably assured that this student will safely and appropriately possess and /or self administer his/her prescribed medication as ordered in the school setting. This student currently demonstrates knowledge, skill and experience of his/her chronic illness and medication.

Nurse Signature: ____ **Date:** ______________