Lincoln Park Performing Arts Charter School

Health Services

LIFE-THREATENING ALLERGY ACTION PLAN

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| --- | --- |
|  |  |
| NAME: | Severe ALLERGY to: |
| Other Allergies: |
|  |
| Please list the specific symptoms the student has experienced in the past: | Asthma Yes (High risk for severe reaction) No |
| School Year: | Date of Birth: Grade: | Routine medications (at home/school): |
| Bus# | Car Walk  Date of last reaction: |
| Location(s) where Epipen®!Rescue medications is/are stored: Health Office  Backpack  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and ca11 911MOUTH Itching, tingling, or swelling of the lips, tongue, or mouthSKIN Hives, itchy rash , and/or swelling about the face or extremities THROAT Sense of tightness in the throat, hoarseness, and hacking cough GUT Nausea, stomachache/abdominal cramps, vomiting, and/or diarrheaLUNG Shortness of breath, repetitive coughing, and/or wheezingHEART "Thready" pulse, "passing out," fainting, blueness, pale GENERAL Panic, sudden fatigue, chills, fear of impending doomOTHER Some students may experience symptoms other than those listed above |

 MEDICATION ORDERED BY PHYSICIAN (Order must be on file)

|  |  |
| --- | --- |
| EpiPen® (0.3) EpiPen Jr.® (0.15)  |  Other epi injector: |
| Repeat dose of EpiPen®: Yes No | If YES, repeat when: |
| Antihistamine (name )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Give: Teaspoons Tablets by mouthHow often: |
| * It is medically necessary for this student to carry an Epipen® during school hours. Yes No
* Student may self-administer Epipen®. Yes No
* Student has demonstrated use to RN Yes No
 |
|  | GIVEN:DATE:TIME: |
|  |  |

ACTION PLAN

* GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.
* NOTE TIME\_\_\_\_\_\_\_\_ AM/PM (Epipen®/adrenaline given) • NOTE TIME\_\_\_\_\_\_\_\_ AM/PM (Antihistamine given)
* CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epipen® is administered.
* DO NOT HESITATE to administer Epipen® and to call 911 even if the parents cannot be reached.
* ALERT 911 student is having a severe allergic reaction and Epipen® is being administered.
* An adult trained in CPR is to stay with student-monitor and begin CPR if necessary.
* Call the School Nurse at x1685 or main office at x1370 immediately.
* Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
* NOTIFY administration and parent/guardian ASAP.

TURN OVER &COMPLETE BACK PAGE

# **BUS**:

* This student carries Epipen® on the bus:
* Epipen® can be found in: Backpack

Yes

 No

* Student will sit at front of the bus:

Yes

 No

* Other (specify):

# **FIELD TRIP:**  (Epipen® should accompany student during any off campus activities)

* Student has permission to self-carry/self-administer on field trip: Yes No
* Staff members on trip must be trained regarding Epipen® use if student is unable to self-administer.
* Other (specify)

# **CLASSROOM: (**For Food allergy only) NO Restrictions

* Student is allowed to eat only the following foods in the classroom:

 Those in manufacturer's packaging with ingredients listed and determined allergen-safe by the

nurse/parent or

 Those approved by parent.

 Middle school or high school student will be making his/her own decision.

 Alternative snacks will be provided by parent/guardian to be kept in the classroom.

 Parent/guardian should be advised of any planned parties as early as possible.

 Classroom projects should be reviewed by the teaching staff to avoid specified allergens.

* Other (specify):

CAFETERIA NO Restrictions

 Student will sit at a specified allergy table.

 Student will sit at the classroom table cleansed according to procedure guidelines prior to student's

arrival and following student's departure.

 Student will sit at the classroom table at a specified location.

* Cafeteria manager and hostess should be alerted to the student's allergy.
* Other:

# EMERGENCY CONTACTS (To be called in order listed)

|  |  |  |
| --- | --- | --- |
| I. | Relationship: | Phone: |
| 2. | Relationship: | Phone : |
| 3. | Relationship: | Phone: |
| 4. | Relationship: | Phone : |

Name of prescribing physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT HAS PERMISSION TO SELF-CARRY EPI-PEN SELF-ADMINISTER EPI-PEN**

FOO

FOO

**THE SCHOOL NURSE MAY CONTACT THE DOCTOR LISTED ABOVE IF NEEDED YES NO**

FOO

FOO

**THE SCHOOL NURSE MAY SHARE THIS ALLERGY INFORMATION WITH STUDENT’S TEACHERS YES NO**

FOO

FOO

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE SCHOOL WILL USE THIS INFORMATION AS AN ALLERGY ACTION PLAN TO PROVIDE THIS STUDENT’S CARE AND TREATMENT AT SCHOOL**