

FAUQUIER COUNTY PUBLIC SCHOOLS HEALTH CARE PLAN FOR SEVERE ALLERGY PART 1

STUDENT NAME: _____ **DOB:** _____ **DATE:** _____

ALLERGIC TO: _____

PHYSICIAN ORDERED MEDICATIONS									
1. Antihistamine: <input type="checkbox"/> NONE OR <input type="checkbox"/> Benadryl/Diphenhydramine HCL: _____ mg/Other: _____									
2. Inhaler: <input type="checkbox"/> NONE OR <input type="checkbox"/> Medication _____ Dose _____									
3. Epinephrine Auto Injector (Epi-pen) 0.30mg <input type="checkbox"/> OR Epinephrine Auto Injector JUNIOR 0.15mg <input type="checkbox"/>									
4. Repeat Epi-pen: <input type="checkbox"/> NO or <input type="checkbox"/> YES, specify when repeat dose to be given _____									
SYMPTOM	GIVE CHECKED MEDICATION								
SEVERE SYMPTOMS following allergen exposure MOUTH: swelling lips/tongue/throat LUNGS: shortness of breath/wheezing/repetitive cough CIRC: weak pulse/low BP/fainting/dizziness/confusion SKIN: widespread hives/flushing or pale/blue skin GUT: severe/repetitive vomiting/diarrhea	<input type="checkbox"/> Epi-pen <input type="checkbox"/> Antihistamine								
MILD SYMPTOMS present from SINGLE SYSTEM MOUTH/NOSE: itchy mouth or itchy/runny nose SKIN: a few hives, mild itch GUT: mild nausea/discomfort	<input type="checkbox"/> Give Antihistamine. Stay with student and alert guardian. Watch closely for changes. If symptoms become severe, give Epi-pen per order.								
MILD SYMPTOMS from MULTIPLE SYSTEMS	<input type="checkbox"/> Epi-pen <input type="checkbox"/> Antihistamine								
SPECIAL CIRCUMSTANCE: Due to severity of allergy history, give Epi-pen upon allergen exposure (allergen confirmed eaten/student stung if bee allergy) even if NO ALLERGY SYMPTOMS PRESENT . YES <input type="checkbox"/> NO <input type="checkbox"/>									
<table style="width:100%; border: none;"> <tr> <td style="width: 30%; border: none;">PHYSICIAN: _____</td> <td style="width: 30%; border: none;">/ _____</td> <td style="width: 30%; border: none;">/ _____</td> <td style="width: 10%; border: none;">/ _____</td> </tr> <tr> <td style="border: none; text-align: center;">Printed Name</td> <td style="border: none; text-align: center;">Signature</td> <td style="border: none; text-align: center;">Phone</td> <td style="border: none; text-align: center;">Date</td> </tr> </table>		PHYSICIAN: _____	/ _____	/ _____	/ _____	Printed Name	Signature	Phone	Date
PHYSICIAN: _____	/ _____	/ _____	/ _____						
Printed Name	Signature	Phone	Date						

1. Note time medications given. **CALL 911** if Epi-pen given. Notify guardian and school administrator.
2. If Antihistamine given for mild symptom only, remain with student and notify guardian. Watch closely for changes as symptoms may worsen and become severe.
3. If symptoms severe, lay student flat, raise legs, and keep warm. Sitting up may help student with breathing difficulties.

PERMISSION TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE/INHALER/ANTIHISTAMINE

I certify that this child has potential for severe allergic reaction and that child has been judged capable of carrying and self-administering the above medications for allergic reaction.

PHYSICIAN SIGNATURE _____ **Self-carry/administration permission granted YES** **NO**

I give consent for my child to carry and self-administer the above ordered medications. My child has been instructed on the recognition of symptoms and the safe/effective use of the ordered medications. My child understands the hazards of sharing medications and has agreed to refrain from doing so. My child knows to notify school staff if medications are used. I will not hold the school board or its employees liable for any negative outcome from my child self-carrying or administering the medications. I understand that this permission may be revoked by the principal to maintain safety.

GUARDIAN SIGNATURE _____ **PRINTED NAME** _____ **DATE** _____
NURSE: ORDER/MEDICATION RECEIPT _____ **DATE** _____

Fauquier County Public Schools Health Care Plan for Severe Allergy-Part 2

STUDENT NAME: _____ DOB: _____ DATE: _____

Date/Description of Last Reaction: _____

Has Epinephrine Been Used in the Past/Explain _____

PARENT/GUARDIAN PHONE (H) _____ (W) _____ (C) _____

PARENT/GUARDIAN PHONE (H) _____ (W) _____ (C) _____

BUS PROCEDURES

1. Emergency Transportation Plan: Given to Guardian Completed/Returned by Guardian
2. Student will sit at the front of the bus: YES NO

FIELD TRIP PROCEDURES

1. The teacher/nurse will discuss field trips with guardian in advance. Guardian encouraged to accompany student on the trip. If cannot attend and student does not have self-administration permission, responsible teacher will carry/ administer medications as ordered, after receiving instruction on the use of the medications from the nurse.
2. The student will remain with the teacher or guardian during the entire trip: YES NO

CLASSROOM

1. Teachers will be notified of allergy. Teacher will review classroom projects to avoid specified allergens.
2. Other: _____

ATHLETICS / EXTRA-CURRICULAR ACTIVITIES

1. Parents are responsible for notifying coach/activity sponsor of student's allergy if student stays after school for athletics/extra-curricular activities/clubs. School nurses are only available during regular school hours.

STUDENTS WITH FOOD ALLERGIES-PLEASE CHECK ALL BOXES THAT APPLY

1. Student will only eat food provided by guardian.
2. Student allowed to eat from school menu, make own food choices, and will seek assistance from cafeteria/clinic staff as needed.
3. Alternative snacks will be provided by guardian to be kept in classroom/clinic.
4. Guardians will be told of planned lessons/parties/activities involving food as early as possible.
5. Student will have NO SEATING RESTRICTIONS in cafeteria.
6. Student requires following cafeteria seating _____
7. Other: _____

Signature gives permission for the principal's designee to administer the ordered medications on Part 1 of this Health Care Plan and to contact the ordering health care provider if necessary to discuss this allergy plan.

PARENT/GUARDIAN SIGNATURE _____ PRINTED NAME _____ DATE _____

ORDERS RECEIVED/REVIEWED BY _____ DATE _____

Notification (initial/date): Admin _____ Transport _____ Teachers _____ Cafeteria _____