ISSAQUAH SCHOOL DISTRICT 411	LIFE-THREATENING ALLERGY PLAN/504	
	Student Name:	
	DOB:	Teacher:
	Grade:	School Year:
	School:	

♦ SIGNS OF AN ALLERGIC REACTION ♦

- **MOUTH** itching, tingling, or swelling of the lips, tongue or mouth
- **THROAT** sense of tightness, itching in the throat, hoarseness, change in voice, throat clearing
- **SKIN** hives, itchy rash, and/or swelling
- **GUT** nausea, stomachache, abdominal cramps, vomiting, and/or diarrhea
- **LUNG** shortness of breath, repetitive coughing, and/or wheezing
- **HEART** fainting, dizziness, weak pulse, blueness, and/or pale skin
- **GENERAL** anxiety, confusion, sudden fatigue, chills, and/or feeling that something bad is about to happen

♦ EMERGENCY ACTION PLAN ♦

If student has symptoms or you suspect exposure to their allergen:

1. **INJECT EPINEPHRINE IMMEDIATELY –** place auto-injector in sharps container after EMS depart.
2. **Adult should stay with student at all times.**
3. **CALL 911 and report that Epinephrine has been administered for an allergic reaction.**
4. **Note time of reaction_______________. Note time(s) medication given_________ and __________.**
5. **Notify parent/guardian, school nurse and school administrator.**
6. **Lay student flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.**
7. **Consider giving additional ordered medications following the Epinephrine Auto-injector:**
   a. **Antihistamine**
   b. **Inhaler if wheezing or breathing difficulties**
8. **If symptoms persist, additional Epinephrine may be administered if ordered and available.**
9. **The student must be transported by medical personnel or a parent and may NOT remain at school.**
10. **Send a copy of the Confidential Health Form with EMS.**
11. **Complete Incident Report.**

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

SEVERE ALLERGY TO:____

Asthma *Yes* ☐ **High Risk for severe reaction No ☐

♦ MEDICATION ORDERS ♦

Give: ☐ Epinephrine Auto-injector **(0.3mg)** ☐ Epinephrine Auto-injector **(0.15mg)**

☐ If symptoms persist after______minutes; give second dose of Epinephrine Auto-injector if available.

Antihistamine____Dosage____

Yes ☐ No ☐ Can this student responsibly **carry** the emergency medication in their backpack/purse?
Yes ☐ No ☐ Can this student responsibly **self-administer** the emergency medication?

Yes ☐ No ☐ Student demonstrated for the LHCP the skill necessary to self-administer the Epinephrine?

Licensed Health Care Professional authorizing administration of above medications:

Signature____ Date __________________________

Print name _______________________________________Phone____________________ Fax______________________

CONFIDENTIAL

♦BELOW TO BE FILLED OUT BY PARENT♦

TRANSPORTATION TO/FROM SCHOOL IS BY: ☐ **Walking** ☐ **Car** ☐ **Bus**

Epinephrine Auto-injector is stored in: ☐ **Health Room** ☐ **Backpack/Purse (LHCP must sign off)** ☐ **Other:**

BUS TRANSPORTATION –The Transportation Department will be alerted to the student's allergy.

- This student carries an Epinephrine Auto-injector on the bus: ☐ Yes ☐ No
- The Epinephrine Auto-injector can be found on the bus in the student's: ☐ Backpack ☐ Waist pack/purse

FIELD TRIPS– Epinephrine Auto-injector should accompany student during any off campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: ☐ Yes ☐ No

CLASSROOM – For Food Allergy only

☐ Foods 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 seating restrictions.
☐ Student will sit at a specified allergy table in the cafeteria. (**Elementary Only**)

Contacts:

1.Parent/Guardian		H:	W:	C:
2.Parent/Guardian		H:	W:	C:
3. Other		H:	W:	C:

- I request this medication to be given as ordered by the licensed health care provider.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- Medical/Medication information may be shared with school staff 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 care provider.
- This permission to possess and self-administer an Epinephrine Auto-injector may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to carry or self-administer.
- Epinephrine Auto-injector auto-injectors exposed to temperatures below 59°F or above 86°F may not function properly. Parents may want to take Epinephrine Auto-injectors home over extended winter breaks when thermostats are set below 59°F. The Epinephrine Auto-injectors must be returned before the student returns to school.
- I request my child be allowed to carry their emergency medication if authorized by physician._____ Yes ____ No
- I request my child be allowed to self-administer their medication if authorized by physician._____ Yes ____ No

Section 504

I acknowledge the evaluation and accommodation plan here provided, and have received a copy of "Your Rights Under Section 504".

____
Parent/Guardian Signature Date

____
School Nurse Signature Date

A copy of the Health Care Plan will be kept in the substitute folder and made available to all staff members who are involved with the student.