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|  qdirconfig002 | **LIFE-THREATENING ALLERGY/504 PLAN**  |  |
| Student Name: |
|  DOB:  | Teacher:      |
| Grade:  |  School Year:  2019 |
| School: Issaquah HS |

**♦ 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
* GENERALanxiety, confusion, sudden fatigue, chills, and/or feeling that something bad is about to happen

**TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL**

Severe allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Route\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **♦ 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.**
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:**
	1. **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 & 911 Checklist.**
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**My signature below gives permission for the school team to evaluate my child for a 504 plan based upon their allergy condition.**

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**♦BELOW TO BE FILLED OUT BY PARENT♦**

**K-5 SCHOOLS– For Food Allergy only- check preferences**

[ ]  Foods approved by parent.

[ ]  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.

[ ]  Egg allergies: may student eat baked goods containing eggs? [ ]  Yes [ ]  No

[ ]  No seating restrictions in cafeteria.

[ ]  Student will sit at a specified allergy table in the cafeteria.

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

**GRADE 6-12 SCHOOLS**---No Seating restrictions. Students make own food choices.

Middle/High school student may self-carry for field trip **(LHCP must sign off)** [ ]  Yes [ ]  No [ ]  N/A

**The Transportation Department will be alerted to the student’s allergy.**

**Epinephrine Auto-injector should accompany student during any off campus activities.**

Epinephrine Auto-injector can be found in:[ ]  **Health Room** [ ]  **With Student** [ ]  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contacts:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.Parent/Guardian  |  |  C:  | W:  | #3: |
| 2.Parent/Guardian |  |  C:  | W:  | #3: |
| 3. Other |  |  C:  | W:  | #3: |

* 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 health condition. I understand themedication(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.
* I understand 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**

By signing below, I acknowledge the accommodation plan provided here, 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 teacher folder and made available to all staff members who are involved with the student.**

Adapted wA

Side 2

Rev 2/2018