TRADERS POINT CHRISTIAN SCHOOLS

(Parents complete pages 1-2 and Physicians complete pages 3-4)

SEVERE ALLERGY Medical Action Plan (MAP)

Student's Name_____

Date of birth_____ **Age**_____ **Grade**_____

Child's picture; face only

CONTACT INFORMATION

Call First(Parent/Guardian)	**Try Second(Parent/Guardian**
Name:	**Name:**
Relationship:	**Relationship:**
Home:	**Home:**
Cell:	**Cell:**
Work:	**Work:**

Call Third (If a parent/guardian cannot be reached)

Name:_____ Relationship:_____

Address:_____

Phone:_____

ALLERGIC HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? **YES NO**

Does your child have Asthma? **YES NO**

****If your child needs medication at school for Asthma, please also complete an Asthma Medical Action Plan**

List all **ALLERGIC FOOD:**

If nuts, please specify by circling on or both of the following: **PEANUT TREE NUT

_____

_____

I request that my child sit at a no nut, food allergy friendly table for meals. **YES NO**

List all **SEVERE ALLERGIES** (such as insects, latex, medications):

_____

_____

List of other foods that should be avoided, but are not a risk for a severe allergic reaction:

_____

_____

If my child is to self-carry epinephrine, I will still supply the school with a back-up. **YES NO**

I agree to have the information in this medical action plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergy to better identify needs. I give permission for trained staff to give the medication(s) as ordered by the Physician for allergic reactions and to contact the Physician for clarifications of orders, if needed.

Parent/Guardian (Printed Name):_____

Signature:_____

Date:_____

Student Name:_____

□ If checked, **give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

□ If checked, **give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted**.

Any <u>SEVERE SYMPTOMS</u> after suspected or known ingestion:

Reaction:	***Response***
One or more of the following: LUNG: Short of breath, wheeze, repetitive cough HEART:Pale, blue, faint, weak pulse, dizzy, confused THROAT:Tight, hoarse, trouble breathing/swallowing MOUTH:Obstructive swelling (tongue and/or lips) SKIN:Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips) GUT: Vomiting, crampy pain	1. **Inject Epinephrine Immediately** 2. Call 911 3. Begin monitoring (See "<u>Monitoring</u>" box below) 4. Give additional medication* (If ordered) -Antihistamine -Inhaler *Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **<u>USE EPINEPHRINE</u>**

MILD SYMPTOMS ONLY:

Reaction:	***Response:***
MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort	1.**Give Antihistamine** 2.Stay with student; <u>Call parent/guardian</u> 3. If symptoms progress: USE EPINEPHRINE (above) 4. Begin monitoring (See below)

<u>Monitoring</u>

Stay with student; call 911 and parent/guardian. Tell rescue squad epinephrine was given. Note time epinephrine was given. <u>A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur</u>. For severe reaction, consider keeping student lying on back with legs raised. Keep head to side if vomiting. Treat student even if parents cannot be reached.

<u>See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area.</u> Directions for use are also printed on the medication. Check expiration date_____when Auto-injector is brought to school.

***For Office Use*: Epinephrine will expire this school year YES NO**

***For Office Use*: Location(s) of auto-injector (epinephrine) in the school _____**

Authorized <u>Physician/Licensed Prescriber Order</u> & <u>Agreement with Protocol</u> in this 2 page plan (see page 1)

<u>Epinephrine dose</u> .15 (junior) .3 (adult) Auto injector brand name if known _____

Two doses are to be made available at school **YES NO**

It is my professional opinion that student should self-carry epinephrine YES NO

<u>NOTE</u>: ***If a student is to self carry their epinephrine, help may still be needed to give the medication.***

<u>Antihistamine</u> name_____ **Dosage** (please do not give a range)_____

<u>Other instructions or orders</u> :

Physician/licensed prescriber name_____

Phone number:_____ **FAX number:**_____

Signature:_____ **Date:**_____