Meridian School District
Each Student will succed through quality, inspirational and innovative education

LIFE THREATENING ALLERGY EMERGENCY ACTION PLAN

Start date: _____day _____mo. _____yr. End date: _____day _____mo. _____yr.

STUDENT NAME: _____ **DOB:** _____ **GRADE:** _____ **SCHOOL:** _____

PARENT CONTACT NUMBERS: Home: _____ Cell: _____ Work: _____

DOCTOR CONTACT NUMBERS: Office: _____ Other: _____

Severe ALLERGY to:	Please list the specific symptoms the student has experienced in the past:
Other Allergies:	Date of last reaction:
Routine medications (at home/school):	Asthma? ☐ Yes (High risk for severe reaction) ☐ No

❖ **ALLERGY SYMPTOMS: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911**

- MOUTH — Itching, tingling, or swelling of the lips, tongue, or mouth
- SKIN — 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 diarrhea
- LUNG — Shortness of breath, repetitive coughing, and/or wheezing
- HEART — "Thready" pulse, "passing out," fainting, blueness, pale
- GENERAL — Panic, sudden fatigue, chills, fear of impending doom
- OTHER — Some students may experience symptoms other than those listed above

❖ ***MEDICATION ORDERS** - To be completed by Licensed Health Care Provider (LHCP)

Epinephrine auto-injector ☐ 0.3 ☐ 0.15	Side Effects:
Repeat Dose of Epinephrine: ☐ YES ☐ NO	If YES, when:
Antihistamine: _____cc/mg	Give:_____Teaspoons _____Tablets by mouth Side Effects:

- ❖ It is medically necessary for this student to carry an Epinephrine auto-injector during school hours: ☐ Yes ☐ No
- ❖ Student may self-administer Epinephrine: ☐ Yes ☐ No
- ❖ Student has demonstrated use to LHCP: ☐ Yes ☐ No

Licensed Health Care Provider's Signature:	Date:
Licensed Health Care Provider's Printed Name:	Phone: Fax Number:

❖ **ACTION PLAN**

- **GIVE MEDICATION AS ORDERED ABOVE … AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES**
  - **TIME Epinephrine given _____AM/PM**
  - **TIME Antihistamine given _____AM/PM**
- **CALL 911 IMMEDIATELY - 911 MUST be called WHENEVER Epinephrine auto-injector is administered.**
- **DO NOT HESITATE to administer Epinephrine and to call 911 if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and Epinephrine is being administered.
- An adult trained in CPR is to stay with the student-monitor and begin CPR if necessary.
- Call the School Nurse at 410-6278
  - **Student** should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
  - **Notify** the Building Administrator and Parent (contact information above)
  - **Dispose** of used auto-injector in "sharps" container or give to EMS along with a copy of the Emergency Action Plan.

INDIVIDUAL CONSIDERATIONS:

- **Bus – Transportation should be alerted to student's allergy**

Yes	No	
☐	☐	This student carries Epinephrine on the bus
☐	☐	Epinephrine auto-injector can be found in: ☐ Backpack ☐ Waistpack ☐ On Student ☐ Other
☐	☐	Student will sit at front of the bus Other(specify)

- **Field Trip Procedures - Epinephrine should accompany student during any off campus activities**

Yes	No	
☐	☐	Student should remain with the teacher or parent/guardian during the entire field trip
☐	☐	Staff members on trip must be trained regarding Epinephrine auto-injector use
☐	☐	Student emergency action plan must be taken along on all field trips and/or off campus activities
☐	☐	Other (specify)

- **Meal Area - For food allergy only**

Yes	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 Other (specify)
☐	☐	Cafeteria manager should be alerted to the student's allergy

- **Classroom – For food allergy only (snacks and parties)**

Yes	No	
☐	☐	Student is allowed to eat only the following foods approved by parent
☐	☐	Middle school and/or high school student will make his/her own decision
☐	☐	Teacher to advise parent/guardian of any planned parties as early as possible
☐	☐	Classroom projects should be reviewed by the teaching staff to avoid specified allergens
☐	☐	Other (specify)

→ 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.

→ I request and authorize my child to carry and/or self-administer their medication. YE^ NO

→ This permission to possess and self-administer an Epinephrine auto-injector may be revoked by the Principal and/or School Nurse if it is determined that my child is not safely and effectively able to self-administer.

- **PARENT SIGNATURE:**

_____ _____ _____

Parent Name Parent Signature Date

For School District Nurse's Use Only

Student demonstrated to the School Nurse the skill necessary to use the medication and any device necessary to self-administer the medication

Device(s) if any used: _____ Expiration Date (s): _____

_____ _____ _____

School Nurse Name School Nurse Signature Date