



CAMAS SCHOOL DISTRICT
A TRADITION OF CARING AND QUALITY

SCHOOL YEAR _____

Guidance for Non-Licensed School Personnel

Emergency Care Plan SEVERE ALLERGIC REACTION

Student: _____

DOB: _____ LEVEL OF CARE: _____

Grade: _____ Teacher: _____

This student is severely allergic to (please check appropriate box(s):

Bee/Insect Stings Nuts/Peanut Butter

Milk Products Latex

Medications _____

Other _____

PHOTO

Signs and Symptoms (can include any or all of the following):
The severity of symptoms can quickly change.

- **Mouth** Itching/tingling of lips & tongue; swelling of lips, tongue, eyes and/or airway
- **Throat** Hurting, itching and/or tightness in the throat
- **Skin** Hives, itching, rash, swelling of face or extremities, generalized flushing
- **Heart** Dizzy, faint, rapid/irregular pulse
- **Stomach** Stomach ache, cramping, diarrhea, nausea and/or vomiting
- **Lungs** Shortness of breath, repetitive coughing, and/or wheezing
- **OTHER** _____

This allergy is potentially life threatening. Do not leave student alone. Never send a student with suspected allergic reaction anywhere alone.

An adult trained in CPR is to stay with student & monitor & begin CPR if necessary.

ACTION FOR MINOR REACTION – To be completed by Licensed Health Care Provider

If the symptom(s) are: rash, flushing, itching, tingling of mouth or known allergy

Give: _____ **RECORD TIME GIVEN** _____

(medication/dose/route/)

Meds located: _____

- **Call office for assistance.**
- **CONTINUE TO OBSERVE FOR ADDITIONAL SYMPTOMS.**
- **If condition does not improve or worsens within 10 minutes, follow steps below for major reaction.**

Notify and follow directions of RN. Contact parent/guardian.

ACTION FOR MAJOR REACTION – To be completed by Licensed Health Care Provider

If the symptom(s) are: difficulty breathing or swallowing, rapid or weak pulse, increased swelling, loss of consciousness, or absence of breathing, mouth or throat swelling.

- **Call office for assistance.**

Give: _____ **IMMEDIATELY! RECORD TIME GIVEN** _____

(medication/dose/route/)

Meds located: _____ **ALWAYS CALL 911 IF ADMINISTERING AN EPI-PEN**

- **CPR trained staff should be prepared to administer CPR if necessary.**

Notify RN (if not in building) & Building Administrator. Contact parent/guardian.

I REQUEST & AUTHORIZE THAT THE ABOVE-NAMED STUDENT BE ADMINISTERED THE ABOVE IDENTIFIED ORAL MEDICATION OR EPI-PEN INJECTION IN ACCORDANCE WITH THE INSTRUCTIONS INDICATED ABOVE FROM _____ TO _____ (NOT TO EXCEED CURRENT SCHOOL YEAR), AS THERE EXISTS A VALID HEALTH REASON WHICH MAKES ADMINISTRATION OF THE MEDICATION ADVISABLE DURING SCHOOL HOURS.

Clinic Name

Licensed Health Care Provider Signature

Date

Telephone

Licensed Health Care Provider (Print or Type Name)

FAX

THIS PORTION TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. I may revoke this authorization by writing to my student's school district. If I did, it would not affect any actions already taken by the school district based upon this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it in conformance with applicable laws. Confidentiality of information provided to my student's school district is protected by the federal Family Educational Rights and Privacy Act. My signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parents/legal guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student. (CSD policy 3419) You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I give the Health Care Professional:

- Permission to fax this form to the school Yes No
- Permission for my student to carry and self-administer inhaler Yes No
- Permission for my student to carry and self-administer EpiPen Yes No

PARENT/GUARDIAN SIGNATURE

DATE

EMERGENCY CONTACTS

1) Parent/Guardian: _____
 Relation: _____
 Phone: _____

2) Parent/Guardian: _____
 Relation: _____
 Phone: _____

3) Emergency Contact: _____
 Relation: _____
 Phone: _____

THIS SECTION BELOW TO BE COMPLETED BY THE SCHOOL NURSE

School Nurse: _____
 Phone: _____
 Cell Phone: _____

The following School Staff are trained and delegated to Administer Medications:

1. _____ Date: _____
 2. _____ Date: _____
 3. _____ Date: _____

Individual Considerations

Bus – Transportation should be alerted to student’s allergy.

- This student carries EpiPen on the bus: Yes No
- EpiPen can be found in: backpack waist pack on student other _____
- Student will sit at front of the bus: Yes No
- Other (specify): _____

Field Trip Procedures - EpiPen should accompany student during any off campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: Yes No
- Staff members on trip must be trained regarding EpiPen use & student emergency care plan (plan must be taken).
- Other (specify) _____

Classroom – For Food Allergy ONLY

- Student is allowed to eat only the following foods: _____
 - Those in manufacturer’s packaging with ingredients listed & determined allergen-safe by the nurse/parent/teachers.
 - Those approved by parent.
 - Middle or high school student will be making his/her own decisions.
 - Alternative snacks will be provided by parent/guardian to be kept in the class.
 - Parent/guardian should be advised of any planned parties as early as possible.
 - Classroom projects should be reviewed by the teaching staff to avoid food allergens.
- Student should have someone accompany him/her in the hallways. Yes No
- Other (specify): _____

Cafeteria NO RESTRICTIONS

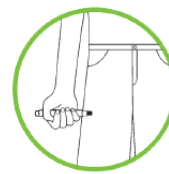
- Student will sit at a specified allergy table
- Student will sit at the classroom table cleansed according to procedure guidelines prior to student’s arrival and following student’s departure.
- Student will sit at the classroom table at a specified location.
- Cafeteria staff should be alerted to the student’s allergy.
- Other (specify): _____



1. Pull off gray safety cap



2. Place black tip on outer thigh (always apply to thigh). May be given through clothing.



3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold and count to 10. The EpiPen unit should then be removed and discarded. Massage the injection area for 10 seconds.