Wrightstown Community School District

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 532-0525 ext. 5016
Health Aide WES Erica Pivonka |(920) 532-4818 ext. 2010| Health Aide WMS Ashley La Roque|(920) 532-5553 ext. 4108
Elementary School Fax (920) 532-4664 |Middle School Fax (920) 532-3869 | High School Fax (920) 532-0860

Allergy/Anaphylaxis Management Plan for School Year: _____

Student Name _____ Date of Birth _____

School Building _____ Teacher _____ Grade _____

Parent/Guardian Name and Phone Number(s) _____

Parent/Guardian Name and Phone Number(s) _____

Emergency Contact Name and Phone Number(s) _____

Allergy to: _____ **Asthma:** ☐ **YES (higher risk for severe reaction)** ☐ **NO**

Describe known symptoms from any previous insect sting, food ingestion, or reaction to nonfood item(s): _____

Complete information in this box if your child is EXTREMELY REACTIVE

Extremely reactive to the following foods /insects/nonfood items (ex. latex): _____
Therefore:

☐ If checked give epinephrine and call 911 immediately for **ANY symptoms** if the allergen was **LIKELY** eaten or come into contact with.

☐ If checked give epinephrine and call 911 immediately if the allergen was **DEFINITELY** eaten or come into contact with **EVEN IF NO SYMPTOMS ARE NOTED**.

Medications to be given at school (IN ORDER BELOW) for allergy/anaphylaxis:

Epinephrine Auto-Injector Type/Brand: _____

Epinephrine Dose: ☐ 0.15 mg injection IM ☐ 0.3 mg injection IM

Antihistamine-medication name/dose: _____

Other-medication name/dose/route: _____

For MILD symptoms after suspected or known ingestion, sting, or contact:

Nose: Itchy/runny nose, sneezing
Mouth: Itchy mouth
Skin: A few hives, mild itch
Gut: Mild nausea/discomfort

→

1. Antihistamine may be given if ordered by a provider and kept at school for student.
2. Stay with person and monitor for changes.
3. If symptoms worsen, give epinephrine
4. Alert parent/guardian or emergency contact.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA GIVE EPINEPHRINE and CALL 911

-Turn Over-

For any SEVERE SYMPTOMS (ANY of the following) after suspected or known ingestion, sting, or contact you must not delay treatment:

Lungs: Shortness of breath, wheezing, repetitive cough
Heart: Faint/dizzy, weak pulse,
pale or cyanotic (blue) skin
Throat: Tightness, hoarse, trouble breathing/swallowing
Mouth: Significant swelling of the tongue or lips
Skin: Many hives over body, widespread redness
Gut: Repetitive vomiting, severe diarrhea
Other: Sense of impending doom (something bad is going to happen), confusion

Or any combination of these.

1. **Inject epinephrine immediately.**
2. **Call 911, state student is having anaphylaxis**
3. Consider giving additional medications if included in plan:
   a. Antihistamine
   b. Other
4. Lay person flat with legs elevated. If breathing is difficult or student is vomiting allow them to sit up or lie on their side.
5. If symptoms don't improve or worsen after 5 minutes, give a second dose of epinephrine if available.
6. Alert parent/guardian or emergency contact.

*Remember antihistamines/inhalers cannot be depended on alone in anaphylaxis

Parent consent for management of health condition while at school or other school-sponsored activities

I, the parent/guardian of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Furthermore, I agree to:

1. Provide the necessary supplies and equipment, including medication in the original. pharmacy labelled container.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify the school staff or school district nurse of any changes in the student's health status.
4. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
5. Ensure this form is signed by the appropriate medical provider (provider who manages the medical condition).
6. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition.
7. School staff interacting directly with my child may be informed about this health care plan.
8. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
9. Hold without liability the Wrightstown Community School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the pertaining school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

☐ **ONLY FOR STUDENTS IN 5th GRADE AND UP** I have instructed the student in the proper way to use his/her medications. **It is my opinion that he/she should be allowed to carry and administer epinephrine by him/herself.**
☐ **It is my opinion that the student should not carry nor administer his/her epinephrine by him/herself.**

Signature of Provider_____ Date_____

School RN Signature _____ Date_____