

**FORT LEAVENWORTH UNIFIED SCHOOL DISTRICT 207 PLAN FOR
MANAGING LIFE-THREATENING ALLERGIES**

Fort Leavenworth USD 207 Plan

Check if considered
life threatening
RED X

USD 207 ALLERGY HEALTH CARE PLAN

Please have physician sign and return this form to your school nurse ASAP

Student Name _____ D.O.B. _____ Grade/Teacher _____

Allergic to _____. Date of most recent reaction _____.
Age allergy diagnosed _____. List the symptoms your child manifests when exposed to the allergen _____

Does your child have an Epi-pen? _____ Will you keep an Epi-pen at school? _____ Does your child know how to use an Epi-pen? _____ Have you ever needed to use an Epi-pen and how many times? _____

USD 207 protocol:

1. If a student exhibits symptoms or an exposure is suspected, student will be sent to the nurse and treatment initiated.

◇ **STEP 1: TREATMENT** ◇

Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† _____
- If reaction is progressing (Several of the above areas affected), give:

Give Checked Medication:**

- | | |
|--------------------------------------|----------------------------------------|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |





The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™0.3 mg Twinject™0.15 mg

Antihistamine: give _____

How to give EpiPen® or EpiPen® Jr

 <p>1 Form fist around EpiPen® and pull off grey cap.</p>	 <p>2 Place black end against outer mid-thigh. Support the child.</p>	 <p>3 Push down HARD until a click is heard or felt and hold in place for 10 seconds.</p>	 <p>4 Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.</p>
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◇ STEP 2: EMERGENCY CALLS ◇

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency Contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE
TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

ALLERGY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

Medications for Allergy

For children requiring rescue medication, the medication is required to be at school at all times while child is in care. For students who self-medicate and carry their own medications, medication must be with the student at all times. Additional medication may be stored in the nurse's office.

Field Trip Procedures

Rescue medications should accompany child during any off-site school sponsored activities.

- The student should remain with staff or parent/guardian during the entire field trip. Yes No
- Staff members on field trip must be trained regarding rescue medication use and this health care plan.
- This plan must accompany the child on the field trip
- Other: _____

Self Medication for Student

- YES** Student can self medicate. I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. Student has been instructed not to share medications and should the student violate these restrictions, the privilege of self medicating will be revoked and the student's parents notified. Student's parents are required to notify staff when carrying medication.
- NO** It is my professional opinion that _____ SHOULD NOT carry or self administer his/her medication.

Bus Transportation Should be Alerted to Student's Condition

- This student carries rescue medications on the bus. Yes No
- Rescue medications can be found in: Backpack Waist Pack On Person Other: _____
- Student will sit at the front of the bus. Yes No
- Other: (specify) _____

I give permission for this information to be shared with adults on a need to know basis. This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the school nurse whenever there is a change in my child's health status or care.

Printed Name of Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)
Printed Name of Student (if self carry medication)	Student Signature	Date (YYYYMMDD)
Stamp of Health Care Professional	Health Care Professional Signature	Date (YYYYMMDD)
Printed Name of School Nurse	School Nurse Signature	Date (YYYYMMDD)