334 W. Central Ave., Zeeland, MI 49464, Phone: (616)772-2609, Fax: (616)772-2706

ALLERGY AND ANAPHYLAXIS INDIVIDUALIZED HEALTHCARE PLAN

This order is valid for the school year (current) _________________, including the summer session.

This form must be completed fully in order for staff at Zeeland Christian School to administer your student's medication. A new Allergy and Anaphylaxis Individualized Healthcare Plan must be completed anytime that there is a change in orders (i.e., time, dosage, interventions, etc.).

- Prescription medication must be in a container labeled by the pharmacist or provider containing the student and medication names, medication dose and route, frequency of administration, the ordering healthcare provider's name, and a current date (unexpired). All information on the medication must match the information provided on this form.
- Non-prescription medications must be in the original container and unexpired, with the label intact, and labeled with the student's name and date of birth.

Student Name: ____ Date of Birth: ___________________Grade: _______________

To be Completed by the Physician or Other Authorized Prescriber

The student is both capable and responsible to self-carry and self-administer this medication: ○ Yes ○ No

Please complete and sign the attached Allergy and Anaphylaxis Emergency Plan or submit a current plan already on file, with signature.

Prescriber's Name/Title (Printed): ____________________________________

Address: ____

Phone: ___________________________ Fax: ____________________________

Prescriber's Signature: ____

Date: ____________________________

(Prescriber Address Stamp)

Parent/Guardian Authorization

I/We request that __________________________________ receive medication as prescribed by the above prescriber on the attached plan when necessary for school attendance. I/we request that the student receive the medication as administered by dedicated school personnel or be permitted to self-carry and self-administer the medication as authorized by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the above named student, including the administration of medication at school. I/We authorize the exchange of information and communication between the health care provider and the school. I agree to inform the school of any changes in medication and/or medical conditions. I realize I may withdraw my request/consent in writing at any time.
If my student will self-administer/self-carry this medication, I agree that in order for them to do so, I will:

- Confirm that my student is able to use correct medication administration technique.
- Instruct my student to never share their medication with another person.
- Have my student carry their medication in its original, properly labeled prescriptive/over-the-counter container, along with a copy of this form.
- Have my student carry, other than inhalers, only that day's supply of medication.

Parent/Guardian Signature: ____ Date: ________________________________

School RN approval for self-carry/self-administration of medication:___________________________________Date:________________

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
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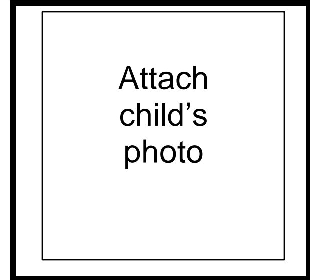
Child's name: ________________________________ **Date of plan:** _______________

Date of birth: ____/____/______ **Age** ______ **Weight:** _________kg

Child has allergy to ____



Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

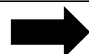
- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): ____________________. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for



If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): ________________________________Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): ______________________________ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): ____

______________________________ ____________ ______________________________ ____________
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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Allergy and Anaphylaxis Emergency Plan

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Child's name: ____ **Date of plan:** ________________________________

Additional Instructions:

Contacts

Call 911 / Rescue squad: ___________________________

Doctor: ____ Phone: _____________________

Parent/Guardian: ____ Phone: _____________________

Parent/Guardian: ____ Phone: _____________________

Other Emergency Contacts

Name/Relationship: ____ Phone: _____________________

Name/Relationship: ____ Phone: _____________________

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SELF-ADMINISTRATION OF EPINEPHRINE STUDENT AGREEMENT

This order is valid for the school year (current) _________________, including the summer session.

Student Name: _____________________________________ Date of Birth: ___________________Grade: ____________________

To be Completed by the Student:

I agree to:

- Follow my prescribing healthcare provider's medication orders.
- Carry my medication in its original container properly labeled with my name, the medication name, the medication dose and frequency of administration, the ordering physician's name and a current date (unexpired) for all prescription medications, or an intact label and current date for all non-prescription medications, labeled with my name.
- Carry a copy of my individualized healthcare plan with the medication.
- Carry, other than inhalers, only a day's supply of medication.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and all field trips.
- Notify the school nurse immediately following administration of my medication.

I understand that permission for self-carry/self-administration of my medication may be discontinued if I am unable to follow the safeguards established above.

Signature of Student:____ Date:_______________________________________

For use by the Nurse:

☐ Student verbalizes correct dosage of medication

☐ Student able to verbalize allergic reaction/anaphylaxis symptoms

☐ Student is carrying medication appropriately with a copy of the individualized healthcare plan

☐ Student demonstrates proper technique for medication administration:

For epinephrine:

1. Removes injector from container if applicable.
2. Removes safety cap(s)
3. Checks medication through viewing window if applicable
4. Demonstrates appropriate placement of injector for administration
5. Explains how to administer epinephrine (follow audible device instructions or inject and hold for 3-10 seconds as applicable to administration device, massage site if applicable)
6. Verbalizes will note time and save syringe for EMS
7. Verbalizes will call 911

☐ Student verbalizes safe use of epinephrine (not sharing, alerting school staff member to contact nurse)

School RN: ____ Date: ______________________________________