

Traders Point Christian Schools

(Parents complete pages 1-2 and Physicians complete pages 3-4)

<p><u>SEVERE ALLERGY</u> Medical Action Plan (MAP)</p> <p>Student's Name _____</p> <p>Date of birth _____ Age _____ Grade _____</p>	<p>Child's picture; face only</p>
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CONTACT INFORMATION

Call First(Parent/Guardian)	Try Second(Parent/Guardian)
Name:	Name:
Relationship:	Relationship:
Home:	Home:
Cell:	Cell:
Work:	Work:

Call Third (If a parent/guardian cannot be reached)

Name: _____ Relationship: _____

Address: _____

Phone: _____

ALLERGIC HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? **YES NO**

Does your child have Asthma? **YES NO**

****If your child needs medication at school for Asthma, please also complete an Asthma Medical Action Plan**

List all **ALLERGIC FOOD:**

****If nuts, please specify by circling on or both of the following: PEANUT TREE NUT**

I request that my child sit at a no nut, food allergy friendly table for meals. **YES NO**

List all **SEVERE ALLERGIES** (such as insects, latex, medications):

List of other foods that should be avoided, but are not a risk for a severe allergic reaction:

If my child is to self-carry epinephrine, I will still supply the school with a back-up. **YES NO**

I agree to have the information in this medical action plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergy to better identify needs. I give permission for trained staff to give the medication(s) as ordered by the Physician for allergic reactions and to contact the Physician for clarifications of orders, if needed.

Parent/Guardian (Printed Name): _____

Signature: _____

Date: _____

Student Name: _____

- If checked, **give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**
- If checked, **give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**

Any SEVERE SYMPTOMS after suspected or known ingestion:

Reaction:
One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

Response

1. **Inject Epinephrine Immediately**
2. Call 911
3. Begin monitoring (See "Monitoring" box below)
4. Give additional medication*
(If ordered)
 - Antihistamine
 - Inhaler

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

Reaction:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

Response:

1. **Give Antihistamine**
2. Stay with student; Call parent/guardian
3. If symptoms progress:
USE EPINEPHRINE (above)
4. Begin monitoring (See below)

Monitoring

Stay with student; call 911 and parent/guardian. Tell rescue squad epinephrine was given. Note time epinephrine was given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For severe reaction, consider keeping student lying on back with legs raised. Keep head to side if vomiting. Treat student even if parents cannot be reached.

See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area. Directions for use are also printed on the medication. Check expiration date _____ when Auto-injector is brought to school.

For Office Use: Epinephrine will expire this school year YES NO

For Office Use: Location(s) of auto-injector (epinephrine) in the school _____

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan (see page 1)

Epinephrine dose .15 (junior) .3 (adult) Auto injector brand name if known _____

Two doses are to be made available at school **YES NO**

It is my professional opinion that student should self-carry epinephrine YES NO

NOTE: If a student is to self carry their epinephrine, help may still be needed to give the medication.

Antihistamine name _____ **Dosage** (please do not give a range) _____

Other instructions or orders :

Physician/licensed prescriber name _____

Phone number: _____ **FAX number:** _____

Signature: _____ **Date:** _____