



# SEVERE ALLERGY/ANAPHYLAXIS MEDICATION ORDER AND HEALTH HISTORY

School Year \_\_\_\_\_

|                      |         |                       |  |                |
|----------------------|---------|-----------------------|--|----------------|
| STUDENT'S LAST NAME: |         | STUDENT'S FIRST NAME: |  | Date of Birth: |
| Grade:               | School: |                       |  |                |

Prior to attendance at school, each child with a life-threatening health condition shall present a medication or treatment order addressing the condition. A life-threatening health condition means a condition that will put the child in danger of death during the school day if a medication and/or treatment order and a nursing plan are not in place. Following submission of the medication or treatment order, a nursing plan shall be developed by the school nurse. Medication and treatment orders are required to be completed each school year. Students with a life-threatening condition will be referred to the 504 Team for evaluation. (WAC 392-380-045, RCW 28A.210.320, SPS Superintendent Procedure 3413SP).

## This Section To Be Completed By A Licensed Healthcare Provider (LHCP):

**When a school nurse is NOT AVAILABLE trained staff will administer epinephrine without delay if a student has a symptom or suspected exposure to the allergen as indicated in Student's Emergency Care Plan (ECP). A student given an Epinephrine Auto Injector must be monitored by medical personnel or a parent and may NOT remain at school.**

Severe allergy to: \_\_\_\_\_

History of Asthma:  Yes (Indicates higher chance of severe reaction. **Asthma Medication Order required for inhaler use at school.**)  
 No

History of Anaphylaxis:  Yes, Date of last reaction: \_\_\_\_\_  Skin Testing Indicates Allergy  
 No

### If a student has symptoms or you suspect exposure (i.e., is stung, eats food allergen, or is exposed to allergen):

- Give Epinephrine (**Seattle Public Schools does not have stock epinephrine**)
  - Auto-injector  0.3 mg  Jr. 0.15 mg
  - Nasal spray  2 mg  1 mg May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved or symptoms return and EMS has not arrived. Document time medications were given and alert EMS when they arrive.
- Stay with student
- CALL 911 - Advise Emergency Medical Services that student has been administered Epinephrine
- Notify parents and school nurse
- After Epinephrine Auto Injector administered, administer Benadryl® or antihistamine \_\_\_\_\_ (ml/mg/cc)
- If student has history of Asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction, after Epinephrine Auto Injector and antihistamine, administer:
  - Albuterol (Pro-air®, Ventolin HFA®, Proventil®) \_\_\_\_\_ puffs
  - Levalbuterol (Xopenex®) \_\_\_\_\_ puffs
  - Other: \_\_\_\_\_
- Permission to carry & self-administer medication:
  - Student has been instructed and is capable of carrying & self-administering EAI
  - Student has been instructed and is capable of carrying & self-administering MDI

### (LHCP) PLEASE COMPLETE THIS SECTION IF THE STUDENT HAS A SEVERE FOOD ALLERGY

**Disability:** Potential anaphylaxis if food ingested. **Major life activity affected:** Potential shut down of multiple body symptoms leading to death.

**How disability restricts student diet:** Student must not eat food containing allergen(s).

**FOODS TO OMIT:** \_\_\_\_\_

Suggested general substitutions: \_\_\_\_\_

|            |                |        |
|------------|----------------|--------|
| LHCP Name: | LHCP Signature | Date   |
| Address:   | Telephone #:   | Fax #: |

**Medication order is valid for duration of current school year which includes summer school.**

**PARENT/GUARDIAN MUST SIGN PAGE 2**

## SECTION TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Identify student's specific response to the allergen:**

- |   |   |
|---|---|
| <input type="checkbox"/> MOUTH--Itching, tingling, or swelling of the lips, tongue, or mouth<br><input type="checkbox"/> THROAT--Tight or hoarse throat, trouble breathing or swallowing<br><input type="checkbox"/> LUNG--Shortness of breath, repetitive coughing, and/or wheezing<br><input type="checkbox"/> GENERAL--Panic, sudden feeling of impending doom | <input type="checkbox"/> SKIN--Hives, itchy rash, and/or swelling about the face or extremities<br><input type="checkbox"/> GUT--Nausea, stomachache/abdominal cramps, vomiting and/or diarrhea<br><input type="checkbox"/> HEART--"Thready" pulse, "passing out", fainting, blueness, pale<br><input type="checkbox"/> OTHER-- _____ |
|---|---|

**History and Current Status**

How many times has your student had a reaction?     Never     Once     More than once, explain: \_\_\_\_\_

When was the last reaction? \_\_\_\_\_

The allergy reactions are:     staying the same     getting worse     getting better

**Symptoms**

What are the signs and symptoms of your student's allergic reaction? (Be specific, include things the student might say.)

\_\_\_\_\_

How quickly do symptoms appear after exposure to the allergen(s)? (seconds, minutes, hours, days) \_\_\_\_\_

|  |                              |                             |                           |                              |                             |
|--|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| My student may carry and self-administer prescribed EAI with LHCP approval:            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Provide extra for office? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| My student may carry and self-administer prescribed asthma inhaler with LHCP approval: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Provide extra for office? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- I request this medication to be given as ordered by the licensed healthcare provider (LHCP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHCP/medical office staff about this plan and medication.
- I understand that the medication may not be administered by a nurse but may be administered by school staff trained and supervised by an RN.
- I release school staff from any liability in the administration of this medication at school.
- I understand that a life-threatening health care plan can only be discontinued, in writing, by the prescribing LHCP.
- Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHCP.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- Permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer the ordered medications.
- By law my signature indicates that I shall hold harmless and indemnify the Seattle School District No. 1, its agents, employees, and board members against all claims, judgements, or liability arising out of self-administration and self-carrying of medication by my student.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature – 18 years or older signing on own behalf (RCW 26.28.015 or RCW 70.02.130): \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

| For School District Nurse Use Only  |                                 |                                   |                                    |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
|---|---------------------------------|-----------------------------------|------------------------------------|---------------------------------------|--|---|---------------------------------|-----------------------------------|------------------------------------|---------------------------------------|--|----------------------|---------------------------------|-----------------------------------|------------------------------------|---------------------------------------|--|
| This student has demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication.   |                                 |                                   |                                    |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| This student may carry and self-administer their medication: <input type="checkbox"/> Yes <input type="checkbox"/> No   |                                 |                                   |                                    |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| Device(s) if any, used: _____   |                                 |                                   | Expiration date(s): _____          |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| <b>Registered Nurse Signature</b>   |                                 |                                   |                                    |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Epinephrine auto-injector (EAI) location:</td> <td style="width: 11%;"><input type="checkbox"/> Office</td> <td style="width: 11%;"><input type="checkbox"/> BACKPACK</td> <td style="width: 11%;"><input type="checkbox"/> ON PERSON</td> <td style="width: 11%;"><input type="checkbox"/> OTHER: _____</td> <td style="width: 13%;"></td> </tr> <tr> <td>Inhaler(s) location:</td> <td><input type="checkbox"/> Office</td> <td><input type="checkbox"/> BACKPACK</td> <td><input type="checkbox"/> ON PERSON</td> <td><input type="checkbox"/> OTHER: _____</td> <td></td> </tr> </table> |                                 |                                   |                                    |                                       |  | Epinephrine auto-injector (EAI) location: | <input type="checkbox"/> Office | <input type="checkbox"/> BACKPACK | <input type="checkbox"/> ON PERSON | <input type="checkbox"/> OTHER: _____ |  | Inhaler(s) location: | <input type="checkbox"/> Office | <input type="checkbox"/> BACKPACK | <input type="checkbox"/> ON PERSON | <input type="checkbox"/> OTHER: _____ |  |
| Epinephrine auto-injector (EAI) location:   | <input type="checkbox"/> Office | <input type="checkbox"/> BACKPACK | <input type="checkbox"/> ON PERSON | <input type="checkbox"/> OTHER: _____ |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| Inhaler(s) location:  | <input type="checkbox"/> Office | <input type="checkbox"/> BACKPACK | <input type="checkbox"/> ON PERSON | <input type="checkbox"/> OTHER: _____ |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| Date EAP Created: _____   |                                 |                                   |                                    |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |
| IEP <input type="checkbox"/> 504 <input type="checkbox"/>   |                                 |                                   |                                    |                                       |  |   |                                 |                                   |                                    |                                       |  |                      |                                 |                                   |                                    |                                       |  |