



LIFE THREATENING ALLERGY
504 Emergency Care Plan
SEVERE ALLERGY to:

No Image
Available

Student Name: **Student Name**

Student Grad Year: Grad Year

DOB: Student Birthdate

Student Grade: Grade

School: School Name

Start Date:

School Year

Teacher:

Student Other Id: Other Id

Transportation:	Walk <input type="checkbox"/>	Car <input type="checkbox"/>	MISD Bus Rider <input type="checkbox"/>	Bus Number:	
Parent/Guardian:	Guardian(s) Primary		Hm Phone:	Guardian(s) Primary Phone	
Guardian 1:	Wk Phone: Guardian(s) Primary Work Phone		Cell Phone:	Guardian(s) Primary Cell Phone	
Guardian 2:	Wk Phone: Guardian(s) Secondary Work Phone		Cell Phone:	Guardian(s) Secondary Cell Phone	
Physician:			Phone:		
Preferred Hospital:					

Drug Allergies:	Asthma?	Yes <input type="checkbox"/>	(High risk for severe reaction)	No <input type="checkbox"/>
Please describe reaction symptoms your student has experienced in the past:			Date of last reaction:	

ALLERGY SYMPTOMS:

<input type="checkbox"/>	MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth	<input type="checkbox"/>	LUNG	Shortness of breath, repetitive coughing, and/or wheezing
<input type="checkbox"/>	SKIN	Hives, itchy rash, and/or swelling about the face or extremities	<input type="checkbox"/>	HEART	"Thready" pulse, "passing out," fainting, blueness, pale
<input type="checkbox"/>	THROAT	Sense of tightness in the throat, hoarseness, and hacking cough	<input type="checkbox"/>	GENERAL	Panic, sudden fatigue, chills, fear of impending doom
<input type="checkbox"/>	GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea	<input type="checkbox"/>	OTHER	Some students may experience symptoms other than those listed above

ACTION PLAN:
If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine Auto-injector and CALL 911
An adult trained in CPR is to monitor student (begin CPR if necessary) until EMS arrives.
Notify Parent/Guardian.
Notify building Administrator.
Dispose of used Epinephrine Auto-injector in "sharps" container or give to EMS.
Give copy of Emergency Care Plan to EMS.

Epinephrine Auto-injector per MD orders:	Time administered: _____AM/PM
Antihistamine per MD orders:	Time administered: _____AM/PM
Inhaler per MD orders:	Time Inhaler administered: _____AM/PM

INDIVIDUAL CONSIDERATIONS:

DISTRICT BUS:

Transportation alerted to students with allergies.				
Student carries an Epinephrine Auto-injector on the bus:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Epinephrine Auto-injector can be found in:	<input type="checkbox"/> Backpack	<input type="checkbox"/> Waist-pack	<input type="checkbox"/> On Person	<input type="checkbox"/> Other:(specify)

DISTRICT FIELD TRIP P & P:

Teacher is responsible for student on field trips.	
Student will remain with the teacher or own parent/guardian during the entire field trip.	
Staff members on trip must be trained regarding Epinephrine Auto-Injector use, understand and have a copy of student health care plan.	

CLASSROOM FOOD:

<input type="checkbox"/>	Student is allowed to eat only the following foods in the CLASSROOM :
<input type="checkbox"/>	Elementary students: Alternative safe snacks must be provided by parent or guardian to be kept in the classroom.
<input type="checkbox"/>	Middle & High school students must be able to review ingredients and then, can make his/her own decision.
<input type="checkbox"/>	Parent or guardian should be advised of any planned parties as early as possible.
<input type="checkbox"/>	Classroom projects should be reviewed by the teaching staff to avoid specified allergens.

CAFETERIA:

<input type="checkbox"/>	No Restrictions
<input type="checkbox"/>	Student will sit at a specified allergy table.
	Food Services Manager alerted to students with food allergies.

ADDITIONAL CLASSROOM ACCOMMODATIONS:

EMERGENCY CONTACTS		
Name	Phone	Relationship
1. Emer Contact 1 Name	Emer Contact 1 Primary Phone	Emer Contact 1 Relationship
2. Emer Contact 2 Name	Emer Contact 2 Primary Phone	Emer Contact 2 Relationship
3. Emer Contact 3 Name	Emer Contact 3 Primary Phone	Emer Contact 3 Relationship
4.		

I request this medication to be given as ordered by the licensed health care provider.

I give Health Services Staff permission to communicate with the medical office about this medication.

I understand the medications(s) may be given by designated staff who is trained and supervised by a school nurse.

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 by the licensed health care provider.

Parent request and permission for student to carry his/her emergency medication. Yes No

Parent request and permission for student to self administer his/her emergency medication. Yes No

***Physician must document approval to self carry and or self administer emergency medication on the Medication Authorization Request Form (MAR).**

*Permission to carry and/or self-administer an Epinephrine Auto-injector, Antihistamine or Inhaler, may be revoked by the principal or school nurse if it is determined that the student can not safely carry and/or effectively self-administer.

Student demonstrated to the nurse the skill necessary to self-administer the medication. Date: _____

504 CONSENT	
<input type="checkbox"/>	I DO ACCEPT this accommodation plan. I am aware that there will be an annual review of plan and periodic evaluations (at least every 3 years). I have received a copy of <i>Section 504 Parent/Student Rights in Identification, Evaluation and Placement</i> .
<input type="checkbox"/>	I DO NOT ACCEPT this accommodation plan. I am aware that there will be an annual review of plan and periodic evaluations (at least every 3 years). I have received a copy of <i>Section 504 Parent/Student Rights in Identification, Evaluation and Placement</i> .
SIGNATURE:	
<input type="checkbox"/>	Parent Signature: _____ Date: _____
<input type="checkbox"/>	Nurse Signature: _____ Date: _____
<input type="checkbox"/>	Physician Signature: (Recommended but not Required) _____ Date: _____