# Mother of God School

## Severe Allergic Reaction & Anaphylaxis Management Plan

**Student's Name:** _____ **Date of Birth:** _____

**Teacher's Name:** _____ **Room #:** _____

**Allergy to:** _____

_____

**Asthmatic (Y/N)?** _____ *(Asthmatics are at higher risk for Severe Reaction)*

## STEP 1: TREATMENT

| Symptoms | Give this Medication | |
|---|---|---|
| | Epinephrine | Antihistamine |
| If a food allergen is ingested or suspected bee sting, but there are no symptoms: | | |
| **Mouth:** itching, tingling, or swelling of lips, tongue, or mouth: | | |
| **Skin:** hives, itchy rash, swelling of the face or extremities: | | |
| **Gut:** nausea, abdominal cramps, vomiting, diarrhea: | | |
| **Throat *:** tightening of the throat, hoarseness, hacking cough: | | |
| **Lung *:** shortness of breath, repetitive coughing, wheezing: | | |
| **Heart *:** weak or "thread" pulse, low blood pressure, fainting, pale, blueness: | | |
| **Other:** | | |
| If reaction if progression (several of the above areas affected): | | |

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

| **DOSAGE**<br>**Epinephrine:** inject intramuscularly: | | |
|---|---|---|
| EpiPen ®<br>Or generic: | EpiPen JR ®<br>Or generic: | Auvi-Q: |
| Antihistamine, give: | | |
| Other, give: | | |

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

## STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad).
2. State that an allergic reaction has been treated and additional epinephrine may be needed.

**Even if a Parent/Guardian cannot be reached, do not hesitate to medicate or take the child to a medical facility!**

_____ Doctor's Name

_____ Doctor's Phone Number

_____ Parent/Guardian Name

_____ Parent/Guardian Phone Number

_____ Emergency Contact Name

_____ Emergency Contact Phone Number

_____ Parent/Guardian Signature & Date

_____ Doctor's Signature & Date

# Mother of God School

## Allergy Prevention Plan

Student's Name: _____ Date of Birth: _____

Teacher's Name: _____ Room #: _____

**Allergy to:** _____

_____

Asthmatic (Y/N)? _____ *(Asthmatics are at higher risk for Severe Reaction)*

**School Will:**

- ☐ Provide a certified Medication Technician on-site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis administering EpiPen® including demonstration and practice
- ☐ Emergency list distributed to: _____
- ☐ Have staff trained on individual emergency plans
- ☐ Make every reasonable effort to prevent the student's exposure to known allergens
- ☐ Other: _____

**Parent Will:**

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans for student medication and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide safe snack options to school/classroom
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

**Student Will:**

- ☐ Make every effort to avoid contact with allergens
- ☐ Alert the nearest adult if he/she suspects exposure to an allergen
- ☐ Other: _____

**Additional Notes:**

_____

_____

# Mother of God School

## Medication Form – Physician's Order

**To be completed by the Physician/Authorized Health Care Providor**

School: _____ Grade: _____ Date of Order: _____

Order Expires at End of School Year (Y/N) or Date: _____ Order Valid for Current Year/Summer (Check if Yes) ☐

Student Name: _____ DOB: _____ Sex: male / female

Name of Medication: _____ Dose: _____ Route: _____ Time to Administer: _____

Reason for Medication: _____ Frequency of Medication (if PRN): _____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

**Parent/Guardian Name:** _____ **Physician Name:** _____ **Phone:** _____

**Parent/Guardian Phone:** _____ **Physician Address:** _____

**Parent/Guardian Signature:** _____ **Prescriber Signature:** _____

**Medication Administration Record (For School Use Only)**

**Nurse Reviewed:** **Dates Reviewed:**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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Name/Postion: Initials: Name/Position: Initials:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

RN Signature: _____ Date: _____

**CODES: Chart Reasong (See H.S. Manual)**

X: School Closed
A: Absent
N: None Available
NS: No Show to HR
D/C: Med Discont.
L/E: Late Arr./Early Dis.
FT: Field Trip
R: Refused
O: Omitted
H: Dose Held

20501 Goshen Road, Gaithersburg, MD 20879 Phone: (301) 990-2088 Fax: (301) 947-0574 www.mogschool.com

# Mother of God School

## Medication Form – Physician's Order

Student Name: _____

| Date | Time | Student Complaint | RN Consulted √ | Medication Administered as Ordered √ | Student Outcome | Staff Initials | Parent Notified √ |
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Reason for Medication: _____ Frequency of Medication (if PRN): _____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

**Parent/Guardian Name:** _____ **Physician Name:** _____ **Phone:** _____

**Parent/Guardian Phone:** _____ **Physician Address:** _____

**Parent/Guardian Signature:** _____ **Prescriber Signature:** _____

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Name/Postion: _____ Initials: _____

_____ _____

_____ _____

_____ _____

_____ _____

RN Signature: _____

Name/Position: _____ Initials: _____

_____ _____

_____ _____

_____ _____

_____ _____

Date: _____

**CODES: Chart Reasong (See H.S. Manual)**

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