Bentonville Schools **Life-Threatening Allergies Plan** Student Photo

Student Name: _____

Grade: _____ Teacher: _____ Date of Birth: _____

Anaphylactic Allergy To: _____

Allergic Reaction: Ingested? __Y__N **Touched?** __Y__N **Inhaled/Airborne?** __Y __N (Attach lab results optional)

Asthmatic: ____Yes* or ____No **If your child is asthmatic, you must also provide an Asthma Action Plan!*

- Due to safety concerns, student will sit at a "nut free/school lunch only" table _____YES _____NO
- Classroom must be "allergen free "(students cannot have products with allergen in class) _____YES _____NO
- Student is allowed to self-carry Epi-Pen: _____YES _____NO Date student trained: _____
- Does child's allergy restrict oral intake or diet, or require food modifications or substitutions? _____YES ____NO
  If YES, list food to be eliminated and possible substitutions:
  Eliminate _____
  Substitute: _____

STEP 1: TREATMENT

Symptoms:		**Give Checked Meds** ** (as Determined by Physician)	
If a food allergen has been ingested, but *no symptoms:*		☐ **Epinephrine**	☐ **Antihistamine**
Mouth	Itching, tingling, or swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itching rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat *	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung *	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart *	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other*	_____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give*:*		☐ **Epinephrine**	☐ **Antihistamine**

Severity of symptoms can quickly change and is potentially life-threatening! Call 911 & send used medication with EMT

DOSAGE

Epinephrine: inject intramuscularly (circle one)

Epi-Pen® Epi-Pen®Jr. Generic Epinephrine (Auto Injector) OTHER: _____

Antihistamine: give:_____

_____ **(Medication: tablet/liquid – dose - route)**

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

STEP 2: EMERGENCY CALLS

1. **Call 911** **State an allergic reaction was treated and additional treatment may be needed!**
2. Dr. _____ Phone Number: _____
3. Parents_____ _____ Phone Number:_____
4. Emergency Contacts: **Name/Relationship** **Phone Number**
   a. _____ _____
   b. _____ _____

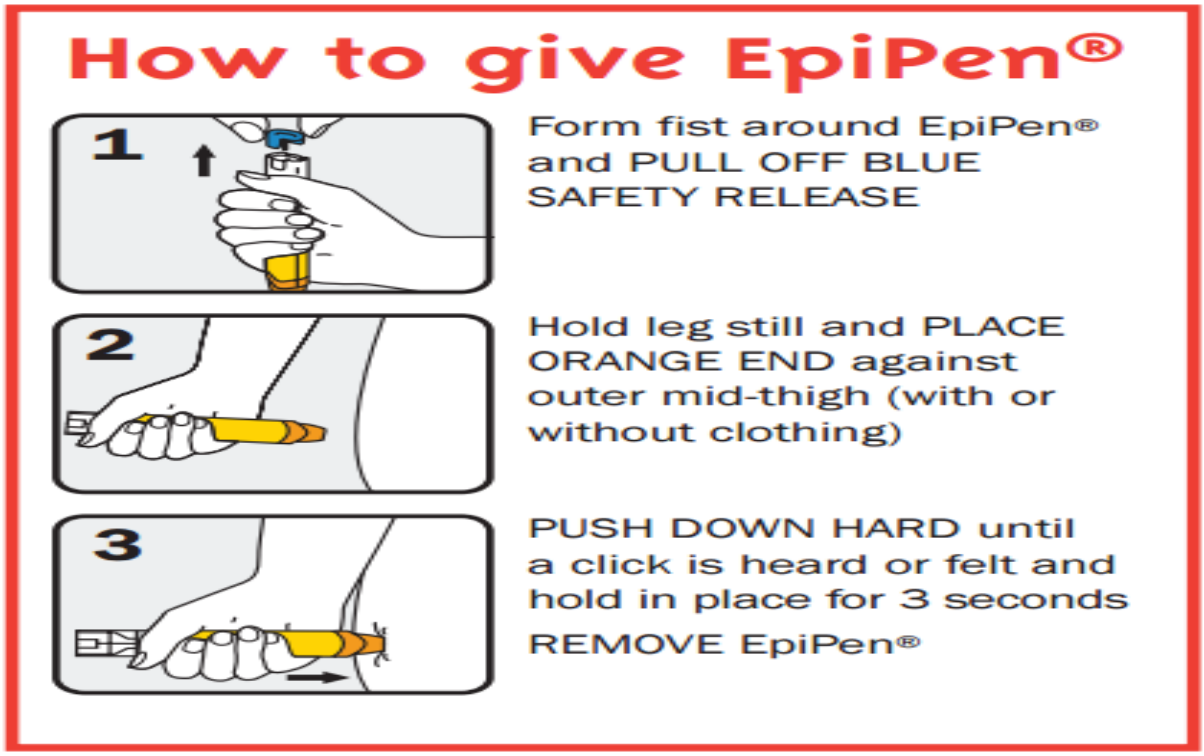
Doctor's Signature _____ **Date**: _____ **(Required)**

Parent/Guardian Signature_____ **Date:** _____ **(Required)**

School Nurse Signature _____ **Date:** _____ **(Required)**

BSD TRAINED STAFF MEMBERS

1. _____	**Date trained:** _____
2. _____	**Date trained:** _____
3. _____	**Date trained:** _____
4. _____	**Date trained:** _____
5. _____	**Date trained:** _____
6. _____	**Date trained:** _____
7. _____	**Date trained:** _____
8. _____	**Date trained:** _____
9. _____	**Date trained:** _____
10. _____	**Date trained :** _____



- **Call 911** Tell rescue squad epinephrine given; request an ambulance with epinephrine.
- **Administer Medication if ordered according to healthcare plan**
- **Give used Medication to EMS personnel when they arrive.**
- **Monitoring - Stay with student - Alert healthcare professionals and parent**.
  1. Note time of Epinephrine administration.
  2. Give Second Dose of Epinephrine 5 minutes or more after the first, if symptoms persist or recur.
  3. For a severe reaction, keep student lying on back with legs raised.
- **Complete and Send** "Report of Epinephrine Administration" **form to Arkansas Dept. of Education**