ISSAQUAH SCHOOL DISTRICT 411	**LIFE-THREATENING ALLERGY/504 PLAN**	
	Student Name:	
	DOB: / Teacher:	picture
	Grade: / School Year:	
	School:	

♦ SIGNS OF AN ALLERGIC REACTION ♦

• MOUTH	itching, tingling, or swelling of the lips, tongue or mouth
• THROAT	sense of tightness, itching in the throat, hoarseness, change in voice, throat clearing
• SKIN	hives, itchy rash, and/or swelling
• GUT	nausea, stomachache, abdominal cramps, vomiting, and/or diarrhea
• LUNG	shortness of breath, repetitive coughing, and/or wheezing
• HEART	fainting, dizziness, weak pulse, blueness, and/or pale skin
• GENERAL	anxiety, confusion, sudden fatigue, chills, and/or feeling that something bad is about to happen

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

Severe allergy to: _____Date of Last Reaction: _____

Asthma *Yes* ☐ **High Risk for severe reaction No ☐

♦ MEDICATION ORDERS ♦

Give: ☐ Epinephrine Auto-injector **(0.3mg)** ☐ Epinephrine Auto-injector **(0.15mg)**

☐ If symptoms persist after_____minutes; give second dose of Epinephrine Auto-injector if available.

Antihistamine_____Dosage _____ Route_____Time_____

Yes ☐ No ☐ Can this student responsibly **carry** the emergency medication in their backpack/purse?
Yes ☐ No ☐ Can this student responsibly **self-administer** the emergency medication?
Yes ☐ No ☐ Student demonstrated for the LHCP the skill necessary to self-administer the Epinephrine?

Licensed Health Care Professional authorizing administration of above medications:

Signature _____ Date _____

Print name _____Phone_____ Fax_____

♦ EMERGENCY ACTION PLAN ♦

If student has symptoms or you suspect exposure to their allergen:

1. **INJECT EPINEPHRINE IMMEDIATELY –** place auto-injector in sharps container after EMS depart.
2. **Adult should stay with student at all times.**
3. **CALL 911 and report that Epinephrine has been administered for an allergic reaction.**
4. **Note time of reaction. Note time(s) medication given.**
5. **Notify parent/guardian, school nurse and school administrator.**
6. **Lay student flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.**
7. **Consider giving additional ordered medications following the Epinephrine Auto-injector:**
   a. **Antihistamine** b. **Inhaler if wheezing or breathing difficulties**
8. **If symptoms persist, additional Epinephrine may be administered if ordered and available.**
9. **The student must be transported by medical personnel or a parent and may NOT remain at school.**
10. **Send a copy of the Confidential Health Form with EMS.**
11. **Complete Incident Report & 911 Checklist.**

My signature below gives permission for the school team to evaluate my child for a 504 plan based upon their allergy condition.
Parent Signature: _____Date:_____

♦BELOW TO BE FILLED OUT BY PARENT♦

K-5 SCHOOLS– For Food Allergy only- check preferences

- ☐ Foods approved by parent.
- ☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- ☐ Parent/guardian should be advised of any planned parties as early as possible.
- ☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ☐ Egg allergies: may student eat baked goods containing eggs? ☐ Yes ☐ No
- ☐ No seating restrictions in cafeteria.
- ☐ Student will sit at a specified allergy table in the cafeteria.
- ☐ Student should remain with the teacher or parent/guardian during the entire field trip: ☐ Yes ☐ No

GRADE 6-12 SCHOOLS---No Seating restrictions. Students make own food choices.
Middle/High school student may self-carry for field trip **(LHCP must sign off)** ☐ Yes ☐ No ☐ N/A

The Transportation Department will be alerted to the student's allergy.
Epinephrine Auto-injector should accompany student during any off campus activities.

Epinephrine Auto-injector can be found in: ☐ **Health Room** ☐ **With Student** ☐ **Other:** _____

Contacts:

1.Parent/Guardian		C:	W:	#3:
2.Parent/Guardian		C:	W:	#3:
3. Other		C:	W:	#3:

- 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 health condition. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- I understand all medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.
- This permission to possess and self-administer an Epinephrine Auto-injector may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to carry or self-administer.
- Epinephrine Auto-injector auto-injectors exposed to temperatures below 59°F or above 86°F may not function properly. Parents may want to take Epinephrine Auto-injectors home over extended winter breaks when thermostats are set below 59°F. The Epinephrine Auto-injectors must be returned before the student returns to school.

- I request my child be allowed to carry their emergency medication **if authorized by physician**._____ Yes ____ No
- I request my child be allowed to self-administer their medication **if authorized by physician**._____ Yes ____ No

Section 504

By signing below, I acknowledge the accommodation plan provided here, and have received a copy of "Your Rights Under Section 504".

_____

Parent/Guardian Signature Date

_____

School Nurse Signature Date

A copy of the Health Care Plan will be kept in the substitute teacher folder and made available to all staff members who are involved with the student.