Healthcare Plan effective for the current school year, including summer school.

Chesterfield County Public Schools
Office of Student Health Services

INDIVIDUALIZED HEALTHCARE PLAN

ANAPHYLAXIS/LIFE-THREATENING ALLERGIC REACTION

To be completed and signed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner).

Student Name:_____D.O.B._____School/Grade:_____

ALLERGY TO:_____ICD-10Code(s) : _____

Student has asthma ☐YES ☐ NO (If YES, higher chance of severe reaction)

Student has had anaphylaxis ☐YES ☐ NO If YES, date of last reaction:_____

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

What to look for	**What to do**
FOR **ANY** OF THE FOLLOWING **SEVERE** SYMPTOMS: • LUNG: Shortness of breath, wheezing, repetitive cough • HEART: Pale or bluish skin, faintness, weak pulse, dizziness • THROAT: Tight or hoarse throat, trouble breathing or swallowing • MOUTH: Significant swelling of the tongue or lips • SKIN: Many hives over body, widespread redness, swelling • GUT: Repetitive vomiting, severe diarrhea • OTHER: Feeling something bad is about to happen, anxiety, confusion **OR A COMBINATION** of symptoms from different body areas ☐ **SPECIAL SITUATION:** If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s):_____ Even if child has MILD symptoms after a sting or eating these foods**, GIVE EPINEPHRINE.**	**GIVE EPINEPHRINE!** • **INJECT EPINEPHRINE IMMEDIATELY!** Note time when epinephrine was given. • **CALL 911.** Advise EMS anaphylaxis suspected and epinephrine has been given. • Keep student lying down. • Notify parent if not already contacted. • Remain with student and observe for difficulty breathing until EMS personnel arrive. • Give a second dose of epinephrine 5 minutes or more after first injection if symptoms get worse, do not improve, or return. • Give other medication, if prescribed (e.g. antihistamine/bronchodilator). *Do not use other medication in place of epinephrine.* • Start CPR if breathing or heart stops. *Follow up care with a health care provider is necessary. The student will not be allowed to remain at school or return to school on the day epinephrine is administered.*

What to look for	**What to do**
FOR **MILD** SYMPTOMS FROM A SINGLE SYSTEM AREA : • NOSE: Itchy or runny nose, sneezing • MOUTH: Itchy mouth • SKIN: A few hives, mild itch • GUT: Mild nausea or discomfort	**Monitor Student** • Give antihistamine (if prescribed) • Watch student closely • Contact parents • If symptoms worsen, *or more than one mild symptom develops*, **GIVE EPINEPHRINE** and follow the directions in the above box

Form adapted from FOOD ALLERGY RESEARCH & EDUCATION (FARE) foodallergy.org and the American Academy of Pediatrics Allergy and Anaphylaxis Plan
Revised 8/22

Medications/Doses

Epinephrine, intramuscular (list type):_____ **Dosage (check one): ☐ 0.15mg ☐ 0.3mg**

Student is capable of carrying their own epinephrine auto injector ☐YES ☐NO
Student has been instructed and is capable of self-administering their own epinephrine auto injector ☐YES ☐NO

Antihistamine, by mouth (type and dose):_____

Other (e.g. inhaler-bronchodilator) type and dose:_____

Additional Instructions: _____

_____

_____

_____

Licensed Healthcare Provider Name (PRINT) **LHP Signature/Date** **NPI#** **Phone Number**

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed this health plan and the *Request for Individualized Healthcare Plan* and agree to the contents.**

☐ Student requires specialized eating location

☐ Student can only have food provided by parent/guardian.

A health conditional may be considered a disability. If you suspect your child may have a disability, request a referral to consider eligibility for 504 or special education services.

_____ _____ _____

Parent/Guardian Name (print) **Parent/Guardian Signature/Date** **Phone number**

_____ _____ _____

School Nurse Name/Signature **Date Received** **Date EAP Distributed**