SUMTER COUNTY SCHOOLS
INDIVIDUALIZED HEALTH CARE PLAN SEVERE ALLERGY (ANAPHYLAXIS)

Date Initiated: _____
Date Reviewed: _____
Date Reviewed: _____
Date Discontinued: _____

Student Name:_____ DOB:_____ School: _____ Grade:_____
Parent/Guardian: _____ Contact #'s: Home _____ Cell _____ Work _____
_____ Home _____ Cell _____ Work _____
Other Emergency Contacts: _____ Contact #: _____
_____ Contact #: _____
Physician: _____ Phone #:_____ Fax #: _____

Medical Diagnosis: _____ Allergies: _____ Medications at Home: _____ at School: _____

History of Asthma Yes No **ESE:** Yes No **IEP:** Yes No **504:** Yes No

Parent Signature: _____ Date _____ Nurse Signature _____ Date _____
Preferred Hospital :_____

Nursing Diagnosis	Goals	Nursing Interventions	Outcome/By Whom/When
1.__ Potential for severe allergic or life threatening episode from: • Peanuts • Bees/ Wasp • Latex • Fire Ants • Shellfish • Eggs • Medication • Other _____	1.__ Student will maintain optimal health and safety necessary for learning.	A.__ Student is allergic to the following: • _____ • _____ • _____ B. __ Events that may cause and allergic response are: • _____ • _____ • _____ C.__ Symptoms of student's allergic response: **Mild Reaction**: itching of skin, raised rash, localized swelling. May progress to a **Severe Reaction**: ___ ***Mouth*** – itching/swelling of lips and tongue ___ ***Throat*** – sudden dry, hacking cough, hoarseness, constricted feeling in chest/throat ___ ***Skin*** – hives, itchy rash, flushed skin, sweating, swelling of face or extremities	

		___ ***Lungs*** – difficulty breathing, wheezing, blue color to lips or nails ___ ***Heart*** – rapid, thread pulse, passing out ___ ***GI*** – abdominal pain, nausea, vomiting ___ ***Mental Status*** – anxiety, fright, confusion D.__ Accommodations needed for severe allergic reaction to: _____ _____ **Mild Reaction:** • remove from causative agent. • Initiate physician's PRN prescribed medication of _____ • If skin irritation, cleanse with soap and water and apply ice. **Severe Reaction:** • **Call 911 (EMS)** • Notify, administration, school nurse and parent/guardian • Don't leave student unattended • Keep student calm and warm. 1.__ School personnel will assist student to avoid: • Exposure to allergens (food, insects, chemicals, etc.) as much as possible. • Student will self-monitor exposure to allergens in order to prevent allergic response - **when age/developmentally appropriate.** **2.__** If symptoms of allergic response/event are noted: • ___ Student will be accompanied to the school clinic, if appropriate. If not, staff will respond to student's location for appropriate intervention. • ___ Follow student's orders as written by the physician. **Medication(s) Dose Time: _____**	Classroom and school personnel Student when age/ developmentally able, school nurse, school personnel

		3.__ Student has: • ___ Epi-Pen (0.3mg) •___ Auvi Q (0.3mg) • ___ Epi-Pen Jr. (0.15mg) •___ Auvi Q (0.15mg) •___ Twin-jet (0.3mg or 0.15mg) available in the following location(s): • ___ school clinic • ___ classroom • ___ other:_____ • ___ other: _____ • ___ other: _____	School nurse, student – as ordered
		4.___ Epinephrine/Benadryl will be administered according to physician's orders. **Document name of trained staff** __ Personnel _____ Date: _____ __ Personnel _____ _____ __ Personnel _____ _____ __ Aide _____ _____ __ Aide _____ _____ __ Aide _____ _____ __ Bus Driver _____ _____ __ Other _____ _____	School nurse, school health staff, school personnel
		5. If epinephrine is administered: •___ CALL 911 (EMS) •___ Notify administration •___ Call parent/guardian	School nurse, trained school personnel
		6.___ Parent/Guardian will be notified when supply of medication needs replacement.	Parent/Guardian – ongoing
		7.___ This plan also covers field trips/after school sponsored activities. These events will be discussed with the parent/guardian in advance so student's medical needs can be accommodated. Trained school staff will accompany student on off campus trips, if needed.	School nurse, trained school personnel – as ordered

2.__ Knowledge deficit related to allergies and possible hidden allergens.	1.__ Student will increase responsibility in preventing and managing allergic response in school.	1.___ The school nurse will provide information on severe allergies and disease management to school staff, as needed, to support the student's needs. 2.___ Student will be provided with ongoing health education and guidance related to severe allergies and treatment according to level of age and learning. 3.___ A copy of the EAP will be given to classroom teacher to be placed in substitute teacher folder, when not in use. 4.__ If needed, a classroom presentation will be given about severe allergies. 5.___ The student's knowledge/understanding of this illness will be discussed with the student, to assess level of awareness and need for update or review.	School nurse, school staff, as indicated School nurse, physician, ongoing, as needed Teachers School nurse, when felt to be beneficial to the student. School nurse, when felt to be beneficial to the student.
3.__ Potential for change in mental status.	1.__ Student will increase knowledge of foods containing allergen by products.	1.___ Parent/guardian will provide school nurse with copy of current physician order's annually or when change in medical status occurs. 2.___ The school nurse will call the student's doctor to obtain current information verbally when this is necessary to manage student's condition at school. Physician or Healthcare Provider Name: Phone #: _____ _____	Parent/Guardian, as needed and annually
4.___ An Individual Health Care Plan (IHCP) will be reviewed annually with parent/guardian and with appropriate school personnel. This plan may be revised/updated as needed to ensure the most current treatment for the student.	1.___ The IHP will be updated and revised annually to meet the health needs of the student.	1.__ Review/updated Date: _____ RN Initials: _____ Parent/guardian Initials: _____ Review/updated Date: _____ RN Initials: _____ Parent/guardian Initials: _____	School nurse, school health staff, parent/guardian, appropriate school personnel

The school nurse, in collaboration with the parent/guardian, will supervise, train and delegate to UAP any portion of this plan as appropriate.		Review/updated Date: _____ RN Initials: _____ Parent/guardian Initials: _____	

☐ **Obtained via telephone interview with parent School Year _____**

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☐ **Obtained via telephone interview with parent School Year _____**

*** As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.**

***Note: 1. Significant changes to the health plan of care requires a new Individual Health Care Plan be completed.**
2. At the beginning of the 4th school year based on the initial date of this plan a new IHCP will be written.