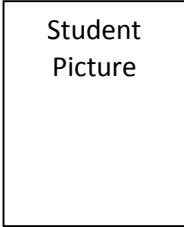


North Thurston Public Schools
 305 College Street NE
 Lacey, Washington 98516-5390
 www.nthurston.k12.wa.us

Student and Staff Support Services
 Phone: (360) 412-4466
 Fax: (360) 412-4555

SCHOOL EMERGENCY ALLERGY PLAN/MEDICATION ORDER/504 PLAN

Student: _____ DOB: _____ Teacher/Grade: _____
 Parent/Guardian: _____ Phone: (H) _____ (O) _____
 Second Contact Person: _____ Phone: _____
SEVERE ALLERGY TO: _____ (Allergen) ASTHMATIC: Yes No



SIGNS OF AN ALLERGIC REACTION

- THROAT* itching and/or sense of tightness in the throat, hoarseness, and hacking cough
- LUNG* shortness of breath, repetitive coughing and/or sneezing
- HEART* "thread" pulse, fainting and/or feeling may "pass out"
- MOUTH itching and swelling of the lips, tongue or mouth
- SKIN hives, itchy rash and/or swelling about the face or extremities
- GUT nausea, abdominal cramps, vomiting and/or diarrhea

The severity of symptoms can quickly change. *Symptoms in any of the top three systems can be immediately life-threatening and symptoms in the bottom three can progress to a potentially life-threatening situation!

IN THE PRESENCE OF ANY OF THE ABOVE SYMPTOMS a child with severe allergies should be monitored continuously.

ACTION

1. If exposure to allergen is suspected, or if child exhibits ANY symptoms, give Epi-pen (inject into thigh and hold for 10 seconds)
2. **CALL 911**
3. Call Parent/Guardian

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!!

Registered nurses cannot delegate assessment and clinical judgment to unlicensed school staff, therefore, Benadryl will not be given first and there cannot be a "wait and watch" period of time. Epinephrine will be administered as ordered.

Medication Orders:		To be completed and signed by Licensed Health Professional			
MEDICATION NAME	HOW MUCH	WHEN TO USE			
_____	_____	_____			
Permission to carry Epi-pen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Permission to carry Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signature of Licensed Health Professional		Name (Please print or type)		Date	
Phone	FAX	Address		City	Zip Code

 Signature of Parent or Legal Guardian

 Signature of School Nurse

 Date

 Date

In health room?	<u>Epi pen</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Inhaler</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
Carries in <input type="checkbox"/> Backpack <input type="checkbox"/> Purse <input type="checkbox"/> Other: _____		
Sports Played _____		
<input type="checkbox"/> Rides bus # _____ or <input type="checkbox"/> Drives _____		