STUDENT NAME___________________________

Anaphylaxis/Severe Allergy/Food Allergy – Individualized Health Care Plan
German International School Washington D.C. (GISW)

Student Name: _________________________________ DOB:_________ School Year: ________

History of Asthma: __ NO __ YES (higher risk for reaction) Bus # (if applicable) _________

Parent/Guardian: _________________________________ Phone(s): ______________________________

Parent/Guardian: _________________________________ Phone(s): ______________________________

Emergency Contact: _______________________________ Phone(s): ______________________________

Notify parent/emergency contact in the following situations:

____

It is the parent's/guardian's responsibility to notify staff of allergies (nurse, teacher(s), front office).

To Be Completed by Health Care Provider

ALLERGENS: (check/list as appropriate)
___ Foods (list): ____

___ Medications (list): ____

___ Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)

___ Stinging Insects (list): ____

Action Plan (**Parent/guardian is responsible for all medication & supplies.**)

		Only Give Checked Medication	
Affected Area	Symptoms	Antihistamine	Epinephrine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of face or extremities		
Gut	Nausea, abdominal cramps, vomiting, diarrhea		
Throat	Tightening of throat, hoarseness, hacking cough		
Lung	Shortness of breath, repetitive coughing, wheezing		
Heart	Thready pulse, low BP, fainting, pale, blueness		
Neuro	Disorientation, dizziness, loss of consciousness		
If progressive reaction affecting several of the above, ADMINISTER:			

The following adaptations/modifications or precautions are required during school hours:
__ Meals in a designated "No-Peanut" zone
__ Classroom teacher(s) will assist student to avoid exposure to allergens as much as possible on a daily basis.

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Other nursing intervention specific to this student: ____

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NOTE: Students showing an allergic reaction should be sent to the nurse immediately. In the event of a sever reaction, the nurse should be called to treat the student at his/her location.

PRESCRIBED MEDICATION

Student will go to the nurse for supervised administration of the following medication(s) unless otherwise ordered in written physician's orders, in accordance with GISW's procedures.

___ Antihistamine: Liquid Diphenhydramine (Benadryl®) dosage: _____________ only if able to swallow
___ Other Antihistamine ___________________________ dosage: _____________ only if able to swallow

If symptoms do not improve in __________ minutes:

___ Repeat medication(s) as ordered by the health care provider.
___ Contact parent/guardian from further instructions
___ Administer Epinephrine only if ordered by physician and provided by the parent
___ CALL 911 EMS

___ *In an emergency*, student is to receive Epinephrine: Inject into outer thigh ___ 0.3 mg OR ___ 0.15 mg. Student is to have emergency medication available to them at all times, but SHOULD NOT carry the auto-injector.

___ Parents are to maintain a supply of medication at school & will be notified when the supplies or medication needs replacement.

Signature of Healthcare Provider: ____ Date: _______________

All changes in medication/treatments must be sent to school in writing signed and dated by the physician

SELF-ADMINISTRATION—MUST BE SIGNED MY HEALTHCARE PROVIDER

This section must be completed by Student's Physician before the student will be permitted to self-administer medication. A student may possess and self-administer medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian. Please indicate if you have provided additional information:

___ This student, ______________________, has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one) and may self-administer: ___ independently ___ with adult supervision

___ This student, _________________, is to have emergency medication (list medication here: ____) with them at all times. It is my professional opinion that this student SHOULD be allowed to carry and use the auto-injector independently. He/she knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.

___ Back-up medication is to be stored at school and **must be provided by the parent/guardian**

Signature of Healthcare Provider: ____ Date: _______________

All changes in medication/treatments must be sent to school in writing signed and dated by the physician

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I, ____, give permission for the information on this form about student, _________________________________, to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. I give consent for the staff of the German Interntaional School Washington D.C. to assist my child to comply with his/her physician's prescribed medications or treatments. I hereby agree to release and hold the staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me contained on this consent form unless it results from the gross negligence of GISW staff. A nurse from GISW will contact the student's parent/guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or will contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. Date of contact & changes ordered by licensed provider notes on attached nurse's note.

Health Care Provider Name: ___________________________________ Telephone #: ______________________

Parent/Guardian Name: _______________________________

Signature: ____

Date: _________________