MS fax 610-759-3262

(The fax goes directly to the nurses office)

Intermediate fax 484-292-1113

**HS fax** 610-849-0863 **Kenneth N. Butz Jr. ES fax** 610-849-0866

**Shafer ES fax** 610-849-0862

Anaphylactic Allergy action plan and dietary needs plan

Lower Nazareth ES fax 610-849-0865

Revised June 2016

Student's name	Grade	Date of birth
tremely reactive to the following:	for ANY symptoms if the allergen was likely eaten.	
	if the allergen was definitely eaten, even if no symptoms a	e noted.
Short of breath, wheezing, repetitive cough pulse, dizzy	1. INJECT EPINEPHRINE IMM  2. Call 911. Tell them the child is having an need epinephrine when they arrive.  • Consider giving additional medications foll  » Antihistamine » Inhaler (bronchodilator) if wheezing  • Lay the person flat, raise legs and keep ware difficult or they are vomiting, let them sit used to the sum of the su	naphylaxis and may owing epinephrine:  rm. If breathing is up or lie on their side. turn, more doses of more after the last dosolve. Person should
redness diarrhea about to happen, anxiety, confusion		
MILD SYMPTOMS	FOR MILD SYMPTOMS FROM MO	
	SYSTEM AREA, GIVE EPINI	EPHRINE.
, , , , , , , , , , , , , , , , , , , ,	FOR MILD SYMPTOMS FROM A S AREA, FOLLOW THE DIRECTION  1. Antihistamines may be given, if of healthcare provider.  2. Stay with the person; alert emerged with the person; alert emerged six of the healthcare provider.  3. Watch closely for changes. If syngive epinephrine.	INGLE SYSTEM ONS BELOW: ordered by a gency contacts.
Itchy/runny Itchy mouth A few hives, Mil nose, mild itch di	FOR MILD SYMPTOMS FROM A S AREA, FOLLOW THE DIRECTION  1. Antihistamines may be given, if of healthcare provider.  2. Stay with the person; alert emerged and the second of the second o	INGLE SYSTEM ONS BELOW: ordered by a gency contacts.
Itchy/runny Itchy mouth A few hives, Minose, mild itch dispersion mild i	FOR MILD SYMPTOMS FROM A S AREA, FOLLOW THE DIRECTIO  1. Antihistamines may be given, if of healthcare provider.  2. Stay with the person; alert emerged and the person and the person are reported by the p	SINGLE SYSTEM ONS BELOW: ordered by a gency contacts. optoms worsen,
Itchy/runny Itchy mouth A few hives, Minose, mild itch dispersion will itch dispersion mild i	FOR MILD SYMPTOMS FROM A S AREA, FOLLOW THE DIRECTIO  1. Antihistamines may be given, if of healthcare provider.  2. Stay with the person; alert emerged and the person and the person are reported by the p	SINGLE SYSTEM ONS BELOW: ordered by a gency contacts. optoms worsen, tion, as indicated by the
Itchy/runny Itchy mouth A few hives, Minose, mild itch dispersion mild i	FOR MILD SYMPTOMS FROM A SAREA, FOLLOW THE DIRECTION  1. Antihistamines may be given, if of healthcare provider.  2. Stay with the person; alert emergency medical strength of the provider.  3. Watch closely for changes. If symplete epinephrine.  Epinephrine:  Ity to self-administer the physician-prescribed emergency medical er name.  Elf-administering his/her medication diagrees to report any side effects to the Nurse Self-administer and carry in school?  Only carry in school?	SINGLE SYSTEM ONS BELOW: ordered by a gency contacts. aptoms worsen, tion, as indicated by the
Itchy/runny Itchy mouth A few hives, Minose, sneezing  SELF-ADMINISTRATION: for Inhalant, Enzyme or E The above named student has demonstrated the abilifollowing criteria:  1. Respond to and visually recognize his/he 2. Identify his/her medication. 3. Demonstrate the proper technique for se 4. Knowledge of medication side effects and Do you recommend that the student:  Epinephrine Brand: Auvi-Q Epi-pen	FOR MILD SYMPTOMS FROM A SAREA, FOLLOW THE DIRECTION  1. Antihistamines may be given, if of healthcare provider.  2. Stay with the person; alert emergency medical strength of the provider.  3. Watch closely for changes. If symplete epinephrine.  Epinephrine:  Itity to self-administer the physician-prescribed emergency medical er name.  Pelf-administering his/her medication diagrees to report any side effects to the Nurse Self-administer and carry in school?  Only carry in school?  Medications/Doses:	SINGLE SYSTEM ONS BELOW: ordered by a gency contacts. hptoms worsen,  tion, as indicated by the YES NO YES NO

## NAZARETH AREA SCHOOL NURSES MS fax 610-759-3262

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**HS** fax 610-849-0863

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Anaphylactic Allergy action plan and dietary needs plan

Student's name	Grade	Date of birth Medication Authorization

## (Physician/Psychiatrist/Dentist and Parent/Guardian)

If your child needs to take medicine in school, prescription or \*over-the-counter, the procedure is as follows: The Nazareth Area School District requires a physician's/psychiatrist's/dentist's written order and a parent's/legal guardian's/emancipated student's authorization for the school nurse, or in her/his absence the designee, to administer medications to students in the regular school setting and only in circumstances when the child's health may be jeopardized without it. Written authorization, signed by the physician, psychiatrist, or dentist (original or by fax) and the parent, legal guardian, or emancipated student must be provided for each separate prescription or medication being administered to each student. If dosage is changed, new written authorization is required. Authorization will terminate with the expiration date of the prescription or at the end of the school year, whichever occurs first. If the medication is discontinued, the parent or legal guardian must notify the school nurse in writing. Medication must be delivered to the school nurse by the parent, legal guardian, authorized adult designee or emancipated student in the original medication container. Students are not to have medication in their possession at any time per school district drug and alcohol policy except physician authorized self-administered emergency medications. It will be the responsibility of the parent, legal guardian, or emancipated student to make arrangements for administration of medication during activities away from school. Medication sent to school in violation of this policy will not be administered to a student. Medication must be in original medication container.

\*See reverse side for medication name, dose, route and frequency Physician's name printed **Address Phone** Signature of Physician/Psychiatrist/Dentist Date <u>Authorization by parent/legal quardian/emancipated student</u> is requested to receive the above medication during school hours in order to maintain sufficient Name of Student health and participation in the school program. We (I) do hereby grant permission for school staff to communicate directly with the physician/psychiatrist/dentist named above. We (I) do hereby release, discharge, and hold harmless NASD, its agents, and employees from any and all liability and claims whatsoever in connection with administration of the above medication to my child. We (I) have read and agree to follow the procedures set forth by the policy and procedure. **Daytime Phone** Signature of Parent/Legal Guardian Date **Medical Statement for Students with Special Dietary Needs** □ N/A The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs. USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose disability restricts their diet and is supported by a statement signed by a licensed physician. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability." The school may choose to accommodate a student with a non-disabling special dietary need that is supported by a statement signed by a recognized medical authority (physician, physician assistant or nurse practitioner). The school food authority may choose to make a milk substitution available for students with a non-disabling special dietary need, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. Does the student have a disability that requires the student to have a special diet? Yes Describe the disability/diagnosis: If student has life threatening allergies, please check when affected: \_\_\_\_ ingestion \_\_\_\_ contact \_\_\_\_ inhalation If the student is NOT disabled, does he/she have a medically certified special dietary need? \_\_\_\_\_ Yes \_ List Special Diet or Dietary Restrictions: (please be specific regarding foods in their natural form vs. as an ingredient) Food Allergies or intolerances: (list specific food(s) to be omitted):\_\_\_\_\_\_ List Allowable Food Substitutions: