Child Health Plan and Provider Orders - Non-Food Allergies

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Center:_____ ☐ Early Head Start ☐ Head Start ☐ ECEAP

Child's Name: _____ DOB: _____ Gender: M / F

Parent/Guardian: _____ Phone: (H) _____ (C) _____

Specific Allergy: _____

Which of the following symptoms occur after exposure?

☐ Hives ☐ Rash ☐ Itching ☐ Swelling ☐ Redness ☐ Tingling ☐ Nausea
☐ Vomiting ☐ Diarrhea ☐ Stomach pain ☐ Gas ☐ Bloating ☐ Other: _____

Give detailed description: _____

Call 911, then call parent/guardian for <u>any</u> of the following symptoms:

- **Mouth:** itching, tingling or swelling of the lips, tongue or mouth
- **Throat:** swelling, sense of tightness in the throat, hoarseness, a hacking cough, trouble swallowing or talking
- **Skin:** very warm or cold to the touch, pale, blue or gray, sweating
- **Gut:** nausea, stomach ache/abdominal cramps, vomiting, and/or diarrhea more than twice
- **Lungs:** difficulty breathing, shortness of breath, repetitive coughing, and/or wheezing
- **Heart:** racing and/or weak pulse, dizziness, fainting or unconsciousness, complaints of chest pain
- **Other:** feelings of anxiety or fear, sudden fatigue, chills, headache, and/or confusion after giving medication

Anaphalaxis Action Plan

- **IF PRESCRIBED BY A PROVIDER, ADMINISTER EPINEPHRINE AS ORDERED** (Epi-pen Jr., Auvi-Q, Twinject)
- **CALL 911 IMMEDIATELY!** 911 must be called **WHENEVER** an **EPINEPHRINE AUTO-INJECTOR** is administered
- **A CPR-TRAINED ADULT** must remain with child at the location where symptoms began until EMS arrives
- **DO NOT HESITATE** to administer **EPINEPHRINE** or call 911 even if the parents cannot be reached
- Advise 911 that child is having a severe allergic reaction and the Epinephrine is being administered
- A CPR trained adult must stay with child at all times, monitor services, and begin CPR if necessary
- Call School Nurse or Health Office per your school district policy
- Give used **EPINEPHRINE AUTO-INJECTOR to EMS** along with a copy of the *Child Health Plan.*

Is medication(s) taken at home? ☐Yes ☐No (list): _____
Is medication(s) needed while at school? ☐Yes ☐No (If YES, refer to provider order's)
Is medication(s) needed during transport to/from school? ☐Yes ☐No

Child's Name: _____ DOB: _____ Gender: M / F

☐No medication is required at school (Please sign below if you agree with this CHP).

Health Care Provider Orders for Medication at School

Important notice to provider:
Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name 2) Symptoms for medication use

3) Dose 4) Frequency & Length of time between doses 5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: _____ **AND** End date: _____

Health Care Provider's Signature Date

Print name Phone # Fax #

Parent/Guardian Signature Date

Interpreter Signature Date

Nurse Consultant Signature Date

ITE/Teacher Date ITP/Assistant Date FA/FE/FSS/HV Date Dir/C Coor Date