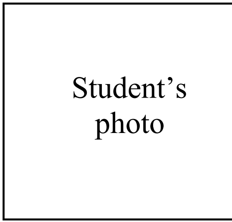
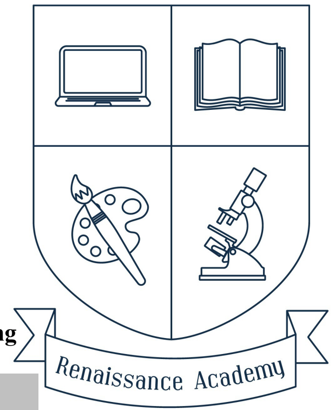
Student Name ____

Renaissance Academy SEVERE ALLERGY Medical Action Plan (MAP)





Date of Birth _________

Age______**Grade**______ **School Year** _____________

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications and any other needed equipment/supplies to Renaissance Academy.

CONTACT INFORMATION

	Contact First	**Try Second**
Parent/ Guardian:	Name: ____________________	Name: ____________________
	Relationship: ____________________	Relationship: ____________________
Phone:	Home: ____________________	Home: ____________________
	Cell: ____________________	Cell: ____________________
	Work: ____________________	Work: ____________________

Call Third (If a parent/guardian cannot be reached)

Name:______________________________________ Relationship:______________________

Address: ____________________________________ Phone: ___________________________

ALLERGIC HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? **YES NO Please list date and details**

Does your child have Asthma? (If yes, at a higher risk for severe allergic reaction) **YES NO**

If your child needs medication at RA for asthma, please complete a separate ASTHMA Medical Action Plan

List allAllergic FOOD If nuts, please specify:

Are your student's allergies Airborne Contact Ingestion

List of Different SEVERE ALLERGIES (such as, Insect sting or Latex)

I agree to have the information in this two-page plan shared with staff needing to know. I understand that my child's name may appear on a listwith other students having severe allergy to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.)

I understand that Renaissance requires an AUVI-Q® auto injector unless student's physician specifies otherwise and I will provide an unexpired device prior to the first day of classes to be kept onsite during the school year. I understand that my student may not attend RA without this. I give permission for trained staff to give the medication(s) as ordered on page 2 of this MAP for allergic reactions and to contact the physician/licensed prescriber for clarification, if needed.

I understand that there is no separate eating area available for students with allergies and no specific supervision of students with allergies. I may choose to attend lunch and personally supervise my student either in the gym or outdoors. I understand that allergens may be on any surface or in the air anywhere in the building.

If my child has contact allergies, I will send appropriate wipes and instruct them to quickly and completely wipe down the table and chair where they will sit for each class. I will further instruct my student as needed to keep themselves safe from accidental exposure as well as what symptoms to be aware of and how to ask or signal for help if needed.

I will notify Renaissance Academy of any change in allergies or sensitivities, including severity or type of reactions to existing allergies and newly developed allergies, aswell as a change in status/date of the last administered Epinephrine auto-injector.

I agree that my student may attend Renaissance Academy based on but not limited to the limitations of allergy protections listed. I will hold harmless Renaissance Academy and anyone associated with it for any aid given or not given, or for any exposure to allergies that my student may suffer in association with their participation in any aspect of Renaissance Academy (includes Renaissance Hybrid Academy and Renaissance Homeschool Group and any other aspect of any of these programs).

Date_______________Parent/Guardian ____

Signature

☐ If box is checked, **give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

☐ If box is checked, **give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted**.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut: Vomiting, crampy pain

1. **Inject Epinephrine Immediately**
2. Call 911
3. Begin monitoring (See "Monitoring" box below)
4. Give additional medication* (If ordered)
   -Antihistamine
   -Inhaler

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

Mouth: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. **Give Antihistamine**
2. Stay with student; Call parent/guardian
3. If symptoms progress: USE EPINEPHRINE (above)
4. Begin monitoring (See below)

Monitoring

Stay with student; call 911and parent/guardian. Tell rescue squad epinephrine was given. Note time epinephrine was given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For severe reaction, consider keeping student lying on back with legs raised. Keep head to side if vomiting. Treat student even if parents cannot be reached.

See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Epinephrine dose ☐**.15 (junior)** ☐**.3 (adult)** Auto injector brand name if known ______________________________ Two doses are to be made available at school **YES NO**

It is my professional opinion that student should self-carry epinephrine **YES NO**

NOTE: ***If a student is to self carry their epinephrine, help may still be needed to give the medication***.

Antihistamine name____________________________________ **Dosage** (please do not give a range) ____________

Other instructions or orders____

Physician/licensed prescriber name____

Phone number ________________________________ **FAX number** _________________________________

Signature____ **Date**_____________________________