717 JORDAN PUBLIC SCHOOLS
Jordan Elementary School
815 Sunset Drive
Jordan, Minnesota 55352
952-492-2336 main | 952-492-4446 fax

NICOLE LANGHEIM | *RN, BSN, PHN, LSN*
LAURA MENDEN | *RN, BSN, PHN, LSN*
District Nurse
jordannurse@isd717.org

RE: SEVERE ALLERGY/ANAPHYLAXIS EMERGENCY CARE PLAN

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has the following allergy:

_____ Peanuts and/or Tree Nuts

_____ Bee Stings

_____ Insects

_____ Other (please list):_____

Please fill out the **"Allergy Questionnaire"** to help understand the nature of your child's allergy and to help better care for your child while he/she is in school. Your child's physician must fill out and sign the **"Severe Allergy/Anaphylaxis Emergency Care Plan"**. Please return the "Allergy Questionnaire" and the "Severe Allergy/Anaphylaxis Emergency Care Plan" before the start of school next fall.

All medication brought to school must be in its **original packaging, unexpired and with its original label** from the pharmacy. Any medication that is expired or without a label will be sent home.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School**	Address: 815 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4446
_____ **Jordan Middle School**	Address: 500 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4450
_____ **Jordan High School**	Address: 600 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4425

Thank you and please call or email us if you have any questions or concerns.

Laura Menden RN, LSN
Nicole Langheim RN, LSN
District Nurses (JES)
952-492-4278
jordannurse@isd717.org

Kelley Harmon LPN (JMS)
952-492-4232
kharmon@isd717.org

Kathy Dunham LPN (JHS)
952-492-4410
kdunham@isd717.org

Severe Allergy/Anaphylaxis Emergency Care Plan
Independent School District 717

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____

LIST ALL ALLERGIES:

EMERGENCY PLAN

		Epinephrine	Antihistamine
If allergen has been ingested or bee sting but no symptoms exist, give:		☐	☐
IF SYMPTOMS, give:			
Mouth	Itching, tingling or swelling lips, tongue, mouth, give:	☐	☐
Skin	Hives, itchy rash, swelling face or extremities, give:	☐	☐
Gut	Nausea, abdominal cramps, vomiting, diarrhea, give:	☐	☐
Throat	Tightening throat, hoarseness, hacking cough, give:	☐	☐
Lung	Short of breath, wheezing, hacking cough, give:	☐	☐
Heart	Weak or thready pulse, low BP, blueness, fainting, pale:	☐	☐

Epinephrine Order (Circle EpiPen dose)

EpiPen 0.3 mg **EpiPen Jr. 0.15 mg** **Twinject 0.3 mg** **Twinject 0.15 mg**

Student was trained and is able to self-administer EpiPen: ☐ Yes ☐ No

Student may self-carry medications: ☐ Yes ☐ No

****If EpiPen is given, call 911!**

Antihistamine Order

Medication Name: _____ Dose: _____ Route: _____ Frequency _____

Other Instructions:_____

Physician Signature_____Date_____

Physician Name_____ Phone Number_____Fax_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent Name _____(h) _____ (w) _____ (c)_____

Parent Name _____(h) _____ (w) _____ (c)_____

Emergency contact:_____(h) _____ (w) _____(c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Allergy Questionnaire
Independent School District 717

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____

Allergy History

1. Please list all allergies:_____
2. When was your child diagnosed with allergies listed above? _____
3. How soon after exposure to the allergen does your child react? _____minutes _____hours _____days
4. Please describe the specific symptoms your child experiences during an allergic reaction: _____
5. Does your child recognize the symptoms of an allergic reaction? ☐ Yes ☐ No
6. When was the last time your child required medication to treat an allergic reaction?_____
7. List medication used to treat reaction_____
8. Does your child have asthma? (Children with asthma have increased risk for respiratory anaphylaxis) ☐ Yes ☐ No
9. What medications will your child have at school for allergies?
   ☐ EpiPen ☐ Antihistamine (Benadryl) ☐ Other_____
   Emergency medication location(s): ☐ Nurse's office ☐ With Student ☐ With Teacher ☐ Kids Company ☐ Other_____
10. Ils your child able to identify what allergen(s) cause an allergic reaction? ☐ Yes ☐ No
11. Please indicate below any modifications requested for your child while in school: (check all that apply):

PEANUT/TREE NUT ALLERGY

In the classroom:

☐ **ALL** snacks will be provided by parent
☐ Student will chose snacks from snack cart
☐ A letter will be sent to classmates' parents requesting they do not send birthday treats with known allergens
☐ A letter will be sent to classmates' parents asking they avoid sending foods with known allergens in *their child's* daily snacks
☐ Teacher will review lesson plans and projects and modify as needed to protect student
☐ NO ACCOMMODATIONS NEEDED

In the cafeteria:

☐ Child will sit at the peanut-safe table
☐ NO ACCOMMODATIONS NEEDED

On the bus:

☐ Child will sit in the first two rows
☐ Parent will introduce student to driver and show driver where EpiPen is located
☐ NO ACCOMMODATIONS NEEDED

BEE STING ALLERGY (Elementary students ONLY)

Recess:

☐ EpiPen will be kept with recess staff during recess
☐ Child will be introduced to recess staff by school nurse

Phy-ed (for outdoor phy-ed in Spring and Fall):

☐ Student will be responsible for getting EpiPen from nurse's office before outdoor phy-ed
☐ Student needs a reminder to get EpiPen before outside phy-ed

Bag Lunch: *(On "Bag Lunch" days students eat outside. Students with allergies to bee stings eat indoors (unless otherwise indicated below) because of the increased risk of bee exposure with the presence of food and drink)*

☐ Student will eat **indoors** on bag lunch days
☐ Student may eat **outdoors** on bag lunch days

A copy of this will be kept in the substitute folders of the nurse and teacher and will be distributed to all staff involved with your child.

Parent Signature_____Date_____

School Nurse_____Date_____