



## Severe Allergy Individualized Healthcare Plan (IHCP)

Student: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Grade: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Student's Secondary Health Concerns: \_\_\_\_\_

**Nursing Diagnosis:** Knowledge Deficit Related to Disease Management & Prescribed Treatment Regimen (NANDA 00126)  
 Risk for Allergy Response Related to History of Hypersensitivity to Allergen (NANDA 00217)  
**Student Goal:** Student Will Demonstrate Understanding of the Disease Process and Management

**Ratings:** 1- No Knowledge, 2- Limited, 3- Moderate, 4- Substantial, 5- Extensive Knowledge, N/A- Not Applicable (Circle One)

Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

### Student Knowledge: Disease Process

Able to Identify Known Allergies	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Describe Common Signs & Symptoms of the Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Describe Potential Complication of Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Verbalizes Lifestyle Changes that may be Required to Prevent/Control Future Complications of Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

### Student Knowledge: Treatment Management

Knowledge of Treatment Regimen	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Knows Importance of Continual Access to Emergency Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Verbalizes Understanding on When to Use Prescribed Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Knows When to Seek Medical Attention/Emergency Treatment	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Understands treatment effectiveness	3 2 3 4 5 N/A	3 2 3 4 5 N/A	3 2 3 4 5 N/A	3 2 3 4 5 N/A

Routinely monitors expiration date	3 2 3 4 5 N/A	3 2 3 4 5 N/A	3 2 3 4 5 N/A	3 2 3 4 5 N/A
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**Student Knowledge: Medication Administration**

Identification & Correct Name of Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Correct Use of Prescribed Medication (Correct Dose, Time, Route)	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Verbalize Medication Side Effects	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Confidence Performing Needed Task	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

**Ratings: 1- Severely Compromised, 2- Substantially, 3- Moderately, 4- Mildly, 5- Not Compromised, N/A- Not Applicable (Circle One)**

**RN Assessment of Student Health Status**

Physical Health	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Mental Health	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
School Attendance	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Readiness to Learn	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Participation In Physical Activities	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Healthy Dietary Habits	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

<b>Completed by:</b>	<b>Completed by:</b>	<b>Completed by:</b>	<b>Completed by:</b>
<b>Nurse's Signature:</b>	<b>Nurse's Signature:</b>	<b>Nurse's Signature:</b>	<b>Nurse's Signature:</b>

**\*Emergency Action Plan Available in Medication Binder, UAP & Student Checklists Completed by RN**

**Additional Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



School Health Program

STUDENT CHECKLIST

Administration of Epinephrine Auto-Injector for Severe Allergic Reactions

Student Name: \_ ID#: \_
School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

This student has demonstrated understanding and competency consistently to:

Table with 4 columns: SKILLS, YES, NO, COMMENTS. Rows include skills like 'State name of medication', 'State why he/she needs the medication', 'State when and why 9-1-1 needs to be called', 'State his/her symptoms of an allergic reaction', and 'Demonstrate the correct procedure for using an auto-injector'.

The student agrees to follow the safety precautions in handling the medication and to have medication on his/her person or safely nearby at all times.

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name/Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby acknowledge that the student listed above has demonstrated all the above listed skills for safe administration of an Epinephrine Auto-Injector.

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

Review Dates: \_\_\_\_\_



**Skills Delegation Checklist for Unlicensed Assistive Personnel (UAP)**

**Severe Allergy**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Person Trained: \_ Position: \_

School Nurse: \_ School Year: \_

**Rating: Y-Yes, N-No, N/A- Not Applicable (Circle one for each item)**

**Epinephrine Auto-Injector**

	<u>Training &amp; Demo Date</u>	<u>Monitoring Date</u>	<u>Monitoring Date</u>
Initiates Emergency Response Protocol	Y N N/A	Y N N/A	Y N N/A
Verifies medication order before administration	Y N N/A	Y N N/A	Y N N/A
Identifies & States Name of Medication	Y N N/A	Y N N/A	Y N N/A
Checks expiration before administering	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of Medication	Y N N/A	Y N N/A	Y N N/A
States Symptoms of Allergic Reaction	Y N N/A	Y N N/A	Y N N/A
States Location of Medication & Emergency Care Plan	Y N N/A	Y N N/A	Y N N/A
Follows Procedure for Administration of Medication	Y N N/A	Y N N/A	Y N N/A
Monitors for Response to Medication	Y N N/A	Y N N/A	Y N N/A
Responds Appropriately to Poor Response to Medication	Y N N/A	Y N N/A	Y N N/A
	Nurse Signature	Nurse Signature	Nurse Signature
	UAP Signature	UAP Signature	UAP Signature



**Skills Delegation Checklist for Unlicensed Assistive Personnel (UAP)**

**Severe Allergy**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Person Trained: \_ Position: \_

School Nurse: \_ School Year: \_

**Rating: Y-Yes, N-No, N/A- Not Applicable (Circle one for each item)**

**Epinephrine Auto-Injector**

	<u>Training &amp; Demo Date</u>	<u>Monitoring Date</u>	<u>Monitoring Date</u>
Initiates Emergency Response Protocol	Y N N/A	Y N N/A	Y N N/A
Verifies medication order before administration	Y N N/A	Y N N/A	Y N N/A
Identifies & States Name of Medication	Y N N/A	Y N N/A	Y N N/A
Checks expiration before administering	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of Medication	Y N N/A	Y N N/A	Y N N/A
States Symptoms of Allergic Reaction	Y N N/A	Y N N/A	Y N N/A
States Location of Medication & Emergency Care Plan	Y N N/A	Y N N/A	Y N N/A
Follows Procedure for Administration of Medication	Y N N/A	Y N N/A	Y N N/A
Monitors for Response to Medication	Y N N/A	Y N N/A	Y N N/A
Responds Appropriately to Poor Response to Medication	Y N N/A	Y N N/A	Y N N/A
	Nurse Signature	Nurse Signature	Nurse Signature
	UAP Signature	UAP Signature	UAP Signature



**Florida Miami Dade DOH School Health Program  
Roles & Responsibilities: Severe Allergies**

Student: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Grade: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 Parent/Guardian Name(s) \_\_\_\_\_ School Year: \_\_\_\_\_

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Epinephrine Auto Injector Kept: Circle below where applicable- Clinic Main Office Classroom Student Book Bag Other: _____	1. Provide medication & supplies for school site. Pick up and replace any expired medication Med Name & Exp. Date: _____ Med Name & Exp. Date: _____	1. Report any signs/symptoms to school staff.
2. UAP to administer medications per MDCPS training (review action plan, recognize symptoms & respond): 1. _____ 2. _____	2. Keep school staff informed of any changes in student condition, medications and updated emergency contact information. Any change in medication regimen requires new medication forms.	2. Do not trade food with others and avoid known food allergens.
3. Staff to contact 911/Parent/Guardian: <u>Administration</u>	3. Available to accompany student on field trip and carry the epinephrine auto injector.	3. If applicable, carry epinephrine auto injector as directed by physician.
4. Staff to direct EMS to the emergency: <u>Administration &amp; Security</u>	4. Severe Food Allergy Only: Provide all meals/snacks for student.	4. Wear a medical identification tag or jewelry.
5. CPR certified staff: _____ _____	5. If applicable, check student is carrying epinephrine auto injector as directed by physician.	5. Demonstrate competence in the use of the Epinephrine auto-injector.
6. School Grounds Prevention- Contact MDCPS Safety & Emergency Management for control of insects & safety of environment	6. Pick up any unused medication at the end of the school year.	
7. Cafeteria: Allergen free table available & clean table with disposable paper towel & MDCPS approved cleanser after every use		
8. Security/Teacher to carry school two-way radio and/or have emergency intercom access		
9. Substitute Teacher Instructions: Copy of <u>Action Plan on Lesson Plan</u>		

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal or School Administration Designee Name

\_\_\_\_\_  
Date

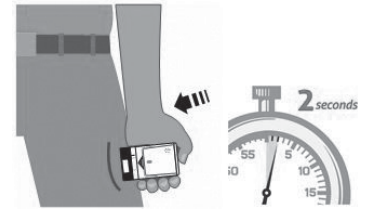
\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date

## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

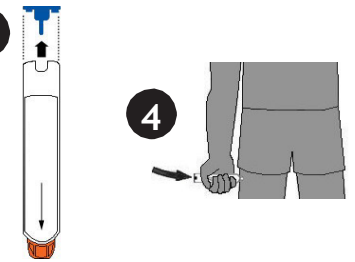
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## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

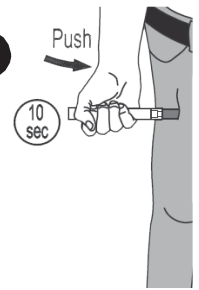
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## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

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## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

5



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

## EMERGENCY CONTACTS – CALL 911

# Child-Specific Training for School Staff

School Year: 20 -20\_

School: \_

Student: \_

Date \_

ID # \_

DOB: \_

Health Condition: Severe Allergies

Medication: Epinephrine Auto-Injector

Staff Name	Signature	Level 1	Level 2	Level 3

School Nurse: \_