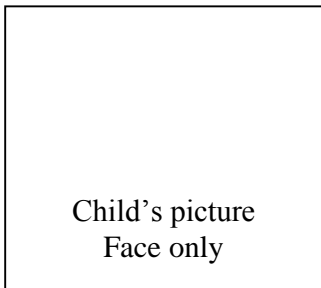


Student Name _____

Attachement B

Rochester Community Schools
SEVERE ALLERGY Medical Action Plan (MAP)



Student's Name _____
Date of birth _____ **School** _____
Age _____ **Grade** _____ **Teacher** _____

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.

CONTACT INFORMATION

Call First

Try Second

Parent/Guardian: Name: _____ Relationship: _____
Phone: Home: _____ Cell: _____ 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

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

If your child needs medication at school for asthma, please complete a separate ASTHMA Medical Action Plan or FORM A for prescribed medication at school (you do not need to do both)

List all Allergic FOOD If nuts, please specify by circling one or both: Peanut Tree Nut

YES NO **I request that my child sit at a no peanut or tree nut table for lunch.**

Other foods to avoid _____

List of Different SEVERE ALLERGIES (such as, Insect stings and Latex)

- YES NO I would like to talk with the school nurse coordinator about my child's allergies
- YES NO If my child is to self-carry epinephrine, I will still supply the school with a back up auto-injector.
- YES NO I would like epinephrine auto injectors kept in more than one school location
- YES NO I have read the attached information regarding section 504 eligibility
- YES NO I wish to be contacted regarding a 504 evaluation

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 list with other students having severe allergy to better identify needs. I give permission to use my child's picture on this plan (if I did not supply a photo.) 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 of orders, if needed.

Date _____ Parent/Guardian _____
Signature

Bus # _____
Driver: _____
Route # _____
Transportation Office Use ONLY if needed
Medical File

- If checked, **give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**
- If 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 911 and parent/guardian. Tell rescue staff that epinephrine was given and the time of administration. 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.

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan (see page 1)

Epinephrine dose .15 (junior) .3 (adult)

YES NO Two doses are to be made available at school

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

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) _____
 (note, liquid is faster acting than a pill form)

Other instructions or orders _____

Physician/licensed prescriber name (Print) _____

Phone number _____ **FAX number** _____

Signature _____ **Date** _____

See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area. Directions for use are also printed on the medication. Check the expiration date when an Auto-injector is brought to school.

For Office Use: Epinephrine will expire this school year NO YES (if yes, when) _____

For Office Use: Location(s) of auto-injector (epinephrine) in the school _____

Rochester Community Schools

Section 504 Notice of Procedural Safeguards

The following is a summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities, as well as certain rights you have under other laws. These include the Individuals with Disabilities Education Act (IDEA) and the Family Education Rights and Privacy Act (FERPA). The intent of the law is to keep you informed about decisions concerning your child, to have you be an active participant in the educational planning for your child, and to inform you of your rights in the event you disagree with any decisions concerning your child's rights under Section 504.

You have the right to:

1. Have the Rochester Community Schools advise you of your rights under federal law;
2. Receive notice with respect to: a) Section 504 identification, evaluation, and/or eligibility determinations of your child; b) your procedural safeguards; c) your opportunity to examine relevant records with regard to your child; and d) your right to an impartial due process hearing, including the right to participate, and be represented by legal counsel, but at your own expense, as well as to request a review of the decision of an impartial hearing officer.
3. Have evaluation, educational programming, and placement decisions made based upon a variety of information sources, and by a team of persons who are knowledgeable about the student, the evaluation data, and placement options;
4. Examine education records related to your child, including those concerning the decisions regarding your child's Section 504 identification, evaluation, educational program, and placement;
5. Obtain copies of educational records at a reasonable cost, unless the fee would effectively deny you access to the records;
6. Receive a response from the Rochester Community Schools to reasonable requests for explanations and interpretations of your child's records;
7. Request an amendment of your child's educational records if there is reasonable cause to believe that they are inaccurate, misleading, or otherwise in violation of the privacy rights of your child. If the Rochester Community Schools refuses this request for amendment, the School District will notify you within a reasonable time and advise you of your right to an impartial hearing;
8. Have your child receive a free appropriate public education, including related services, if he/she is found to be a qualified student with a disability. The services will be without cost to you or your child, except for those fees that are imposed on non-disabled students or their parents or guardians.
9. Have your child take part in, and receive benefits from, the School District's education programs without discrimination because of his/her disabling condition(s);
10. Have your child be educated with non-disabled students to the maximum extent appropriate. This includes the right to have the Rochester Community Schools make reasonable accommodations to allow your child an equal opportunity to participate in school and school related activities;
11. Have your child educated in facilities and receive services comparable to those provided non-disabled students;
12. Have transportation provided to and from an alternative placement setting at no greater cost to you than would be incurred if the student were placed in a program operated by the Rochester Community Schools;
13. Have your child be given an equal opportunity to participate in nonacademic and extracurricular activities offered by the Rochester Community Schools;
14. Request an impartial due process hearing regarding the Section 504 identification, evaluation, eligibility, placement or provision of a Free Appropriate Public Education ("FAPE") for your child.
15. File a complaint in accordance with the Rochester Community Schools' Section 504 grievance procedure.