Plan of Care – SEVERE ALLERGY TO: PEANUTS

**** REACTIONS CAN OCCUR FROM EATING, TOUCHING, AND SMELLING ****

Student: _____ **Grade:** _____

AVOID:	PREVENTION:
• Peanuts	• Cafeteria staff informed about allergy and will check labels, meet student
• Peanut Butter	• Student will be shown products she/he should not choose in cafeteria
• Peanut Oil	• Class parents informed about peanut allergy and requested not to send peanut items for class events
	• Classmates will have session with nurse explaining peanut allergy
	• "Peanut Allergy Classroom" signs will be posted in the room
	• Sub teacher alert with picture will be placed in teacher's sub folder
	• Teacher will know how to administer Epi-Pen
	• Epi-Pen on all field trips

IF YOU SEE THIS:	DO THIS:
• Reported or suspected ingestion	• Stay with student, keep student quiet
• Hives	• Page nurse and state student's name, state allergic reaction to peanuts so nurse can bring medication
• Itchy Skin	• Administer Epi-Pen
• Hives spreading over body	• Call 911 immediately
• Wheezing, difficulty swallowing or breathing	• Call Parent
• Swelling of face, lips, or neck	• Tell EMS that Epi-Pen was given and the time given
• Tingling/swelling of tongue	
• Vomiting/diarrhea	
• Extreme paleness/gray color, clammy skin	
• Loss of consciousness	

Contact: **911**

School Nurse: _____ Principal: _____

Parent/Guardian: _____ Phone: _____

DIRECTIONS FOR USE OF EPI-PEN

1. Pull off gray cap
2. Place black tip against outer thigh, halfway between knee and hip
3. Press firmly until you hear a click
4. Hold in place for 10 seconds, then remove
5. Do **NOT** return Epi-Pen to holder after use, give to EMS personnel or discard in sharps container
6. Remind Parent/Guardian to get replacement Epi-Pen to school as soon as possible

Student may carry Epi-Pen with them while at school or while at a school function after school hours.

❖ _____

(Parent/Guardian Signature)

❖ _____

(Principal Signature)

❖ _____

(School Nurse/Aide Signature)

_____ _____

(Signature of Parent/Guardian) **(Date)**

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Documentation of Participation and Acknowledgement of Plan Trained/Reviewed Use of Emergency Medications:		
Title	**Name**	**Date**
Principal		
Assistant Principal		
Nurse		
Clinic Backup		
Clinic Backup		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Other		
Other		