

Policies of the Board of Education

Section I Students

MANAGING STUDENT ALLERGIES

900.42

The Lake Country School District recognizes the seriousness of adverse allergy reactions and recognizes that allergic reactions can escalate into life-threatening medical conditions. The District cannot guarantee an allergy free environment, but will make every reasonable effort to reduce the risk of exposure to allergens in the school environment.

The District will be responsible for working with individual students who have serious adverse allergy conditions and their parents/guardians to develop and implement allergy action plans. The District will also implement system-wide practices to minimize the presence of allergens in the school environment and to increase the capacity of all district employees to understand, prevent and respond to adverse allergy-related incidents. The District will use a proactive, comprehensive, team approach to work toward the following goals:

- Provide a safe and healthy learning environment for all students;
- Provide students with allergies full access to school activities;
- Reduce the likelihood of severe or potentially life-threatening allergic reactions;
- Ensure rapid and effective responses to severe or potentially life-threatening allergic reactions; and
- Provide appropriate, continuing allergy management-related education and training to District employees.

When appropriate or required by law, each student with a serious, disabling, and/or life-threatening allergy condition shall have an individual allergy action plan based on the student's individual needs and treatment protocol as prescribed by the student's health care provider for use in the school. An individual allergy action plan shall be established through the office of the School Nurse, except as otherwise required by law. When an allergy action plan is incorporated into a 504 Plan or individual education plan (IEP) the plan will be established in accordance with all applicable state and federal laws, and in consultation with the School Nurse.

The District expects that all school personnel, students, and parents/guardians will work cooperatively to accomplish the goals of this policy and will demonstrate respect and an understanding for students with adverse allergy conditions.

WASB Code: 453.61

Adopted by School Board: April 21, 2015

LAKE COUNTRY SCHOOL DISTRICT – ALLERGIC REACTION INDIVIDUALIZED HEALTH PLAN

Student Name	Home Phone Number
Mother's Name	Work Phone Number
Father's Name	Work Phone Number
Physician	Physician's Phone Number

ALLERGIC TO: _____

Please check your child's typical allergic reaction symptoms....

- | | | |
|---|---|--|
| <input type="checkbox"/> difficulty breathing or wheezing | <input type="checkbox"/> violent abdominal pain | <input type="checkbox"/> swelling of face throat or tongue |
| <input type="checkbox"/> change in voice quality | <input type="checkbox"/> collapse | <input type="checkbox"/> hive like skin reaction or swelling |
| <input type="checkbox"/> seizure | <input type="checkbox"/> other | |

Treatment Plan:

1. Call the school nurse
2. Call 911 to transport to Waukesha or Oconomowoc Hospital for severe allergic reaction.
3. Give injection of: _____ EPI-Pen 0.3 mg Epinephrine
 _____ EPI-Pen Jr. 0.15 mg Epinephrine

Physician is to indicate dose. Injection is to be self administered by student or school nurse. No school employee, except a health care professional is required to administer any drug to a pupil by means other than ingestion. WI ACT 334

4. Administer any additional medications physician ordered below.
5. Administer CPR if necessary.

Parental Consent:

- I hereby give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my child according to the directions stated below.
- I give permission to the school nurse to contact the student's physician.
- I further agree to hold the Lake Country School District, and the above-identified person(s), harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
- I agree to notify the health room at the termination of this request or when changes in the below orders is necessary.
- If I cannot be reached by phone and my child does not respond to the medication listed below, 911 will be called to transport my child to the nearest hospital.

Date

Signature or Parent/Legal Guardian

TO BE COMPLETED BY A PHYSICIAN

For School Year _____

MD ORDERS

➡ **Epinephrine:** _____ 0.3 mg IM **OR** _____ 0.15 mg IM _____ May repeat dose in 15 min.

➡ **Middle School or High School ONLY: Student may self-carry medications:** _____

➡ **Antihistamine:** _____

➡ **Other Medication(s):** _____

EPI-Pen – May student self-administer and keep the EPI-Pen under their control in such place as their backpack, purse or pockets? _____ YES _____ NO

Date

Physician Signature