HOLY GHOST PREPARATORY SCHOOL
2429 BRISTOL PIKE, BENSALEM, PA 19020-5298
(215) 639-2102 • FAX (215) 639-4225
WWW.HOLYGHOSTPREP.ORG

SEVERE ALLERGY

Student's Name:_____________________________ Date:__________________

The following information is requested on students known to have significant allergic reactions to bees, insects, food, (nuts, seafood, fruit etc.), latex, environmental agents or common medications which may be administered at school such as Tylenol, ibuprofen, or Benadryl.

My child has a severe allergic reaction to:____
Date of last reaction:____
Symptoms of reaction:

- ☐ severe swelling of ________________
- ☐ vomiting
- ☐ itchy skin
- ☐ hives spreading over body
- ☐ violent sneezing
- ☐ wheezing, difficulty swallowing/breathing (face, neck), tingling/swelling of tongue

The following is the school district procedure for a severe allergic reaction. Please review this plan with your health care provider and return it to school. Your health care provider may want to write additional orders or prefer a different plan of emergency care.

Benadryl is given according to the severity of symptoms. Benadryl 25 mg is given for students 12 years or older, 12.5 mg is given for students 6-12 years. Benadryl will not be administered to a student who is pregnant or is on a monoamine oxidase inhibitor.

The child will be observed for progressing of symptoms.
Severe symptoms will be treated with an Epipen 0.3 mg for students weighing 65 lbs. and over, 0.15 mg for students under 65 lbs. **911 will be called immediately if an Epipen is used or at the nurses discretion for the safety of a child.**
At the nurse's discretion, other comfort measures may be administered to the child including oxygen and increasing fluid intake.

Health Care Provider treating severe allergy:_________________________Phone:__________
____
Is your child able to self-administer his/her Epi-pen?____________________

Any medications must be accompanied by an order from the health care provider.

_____________________________________ ________________
Signature of parent Date

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CONTRACT BETWEEN STUDENT, PARENT, HEALTH CARE PROVIDER AND NURSE

For permission to carry and self-administer Epinephrine

Student name:____________________________ Date:_______________

1. Student has demonstrated the understanding of:
   a. circumstances of his/her specific allergy
   b. symptoms of severe reaction or anaphylaxis and identifying the need for epinephrine
   c. mastery of technique of administration of Epinephrine
2. Student agrees to NEVER share Epinephrine with another person
3. Student agrees to seek adult help IMMEDIATELY from the school nurse or another adult in the event of exposure to a known allergen (regardless whether or not epinephrine was administered)

I give permission for my child,______________________ to carry and self-administer epinephrine. I agree with and understand that s/he must follow the rules listed above. In the event that epinephrine needs to be administered, I understand that 9-1-1 will be called, oxygen will be administered, and my child will be transported *to the nearest available hospital* for continued medical support and care. I will notify the school of any changes in my child's medication or medical condition.

Expiration Date of Current Epinephrine:_________________________________

______________________________________	______________________
parent/guardian signature	date
______________________________________	______________________
student's signature	date
______________________________________	______________________
Health Care Provider Signature	date
______________________________________	______________________
Health Care Provider Name (please print)	office phone