ROCORI AREA SCHOOLS
ISD #750
Allergy Care Plan

Student's Name: _____ Birth Date: _____

Grade: _____ School Year: _____

School: _____

Allergy Emergency Protocol

The student is allergic to _____

If an allergic reaction is suspected, immediately determine the symptoms and treat the reaction as follows:

Symptoms		Give Medication (Check appropriate boxes)		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	□ Antihistamine	□ EpiPen	□ Other _____
Skin	Hives, swelling on face or extremities, itchy rash	□ Antihistamine	□ EpiPen	□ Other _____
Gut	Nausea, abdominal cramps, vomiting, diarrhea	□ Antihistamine	□ EpiPen	□ Other _____
Throat	Tightening of throat, hoarseness, hacking cough	□ Antihistamine	□ EpiPen	□ Other _____
Lung	Shortness of breath, repetitive coughing, wheezing	□ Antihistamine	□ EpiPen	□ Other _____
Heart	Thready pulse, passing out, fainting, pale, blueness	□ Antihistamine	□ EpiPen	□ Other _____
General	Panic, sudden fatigue, chills, fear of impending doom	□ Antihistamine	□ EpiPen	□ Other _____
If a food allergen has been ingested, but no symptoms:		□ Antihistamine	□ EpiPen	□ Other _____
If a reaction is progressing (several of the above areas affected):		□ Antihistamine	□ EpiPen	□ Other _____

Call 911 and parent if:

- Student had a severe allergic reaction and additional epinephrine doses may be needed

If you want additional help given or have other concerns, describe here: _____
_____
_____
_____
_____

Medication Information

Are medications needed to control the allergy? □ No □ Yes

Medication	Dose	Route	Frequency	Administer at School?

** If a prescription medication is to be administered at school, a medication authorization form needs to be completed by prescribing physician*

EpiPen and EpiPen Jr. Directions:

- Pull off gray activation cap
- Hold back tip near outer thigh (always apply to thigh)
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen and massage the injection site for 10 seconds.
- Once EpiPen is used, call 911. State additional epinephrine may be needed. Take the used unit with you to the Emergency Room. Plan to stay for observation.

Emergency Contact Information

In the event of an emergency, the following individuals should be contacted:

	Name	Relationship	Phone Number(s)
1.	_____	_____	H: _____
			W: _____
			C: _____
2.	_____	_____	H: _____
			W: _____
			C: _____
3.	_____	_____	H: _____
			W: _____
			C: _____

Hospital of choice: _____

Parent/Guardian Consent

I will notify the health office immediately of any medication changes. I will advise the school of changes in contact information, emergency contact persons, or physician/hospital preferences.

_____ _____

Parent Signature Date