# SEVERE ALLERGY-ANAPHYLAXIS HEALTH CARE PLAN

(requiring Epinephrine and/or Antihistamine)

Student ______________________________________________ DOB ________________

Allergy to ______________________________________ Bus Rider? ______ Yes ______ No

Circle specific ***usual*** allergy symptoms:

- ***Mouth*** itching & swelling of the lips, tongue or mouth
- ***Throat*** itching and/or a sense of tightness in the throat, hoarseness, hacking cough
- ***Skin*** hives, itchy rash, and/or swelling of the face of extremities
- ***Gut*** nausea, abdominal cramps, vomiting, and/or diarrhea
- ***Lung*** shortness of breath, repetitive coughing and/or wheezing
- ***Heart*** "thread" pulse, passing out

**The severity of symptoms can quickly change. All of the above symptoms can potentially progress to a like-threatening situation!**

**LOCATION OF STUDENT'S MEDICATIONS**________________________________________

In the event that this student requires administration of his/her epi-pen:

- **DO NOT LEAVE STUDENT UNACCOMPANIED.** If the epi-pen is located in the health office, notify the office to bring the epi-pen to your location.
- Designate a staff member to call the school office. They will activate the 911 system, notify the building principal, school nurse, student's parent and district office. Office will make a copy of the student's emergency form for EMS.
- Follow the directions on the reverse side of this sheet to administer.
- Note the time of injection.
- Save the used epi-pen for EMS

**Parent and Emergency Contacts**

Parent/Guardian Name: ______________________________ Daytime Phone # (s)____________________

Emergency Contact:_________________________________ Daytime Phone # (s)____________________

Prescribing Physician: ______________________________ Daytime Phone # ____________________

- As parent/guardian of ___________________________, I give permission for this plan to be available for use in my child's school and for the school nurse to contact the physician listed by phone, fax or in writing when necessary to complete this plan.
- It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school nurse is responsible for delegation of this plan to unlicensed personnel when appropriate.
- This plan will be reviewed annually and/or whenever the health status or medication change and it is the responsibility of the parent to notify the school nurse of these changes.

**Dosage: To Be Completed by Health Care Provider Only**

Epinephrine: Inject into outer thigh __ 0.3 mg OR __ 0.15 mg Antihistamine: Diphenhydramine ____ mg (liquid or fastmelts)

Health Care Provider Signature ____________________________________________ Date ______________

Parent Signature ________________________________________________________ Date ______________

A trained epipen provider should be present on all activities off campus *forms/students/severe-green 0813*