### Individual Health Care Plan for Life Threatening Allergies

**School Year:** _______________  
**Expires at end of current school year**

#### Student Information
- **Student Name:** _____________________________________________________________
- **DOB:** _______________  
- **Weight:** _______________

#### Allergy Details
- **Allergy to:** __________________________________________________________________________________________
- **Had allergic reaction on the following date:** ______________  
- **Required Epinephrine:** [ ] Yes [ ] No
- **Describe reaction:** _____________________________________  
- **Has asthma:** [ ] Yes [ ] No

#### SEVERE SYMPTOMS:

<table>
<thead>
<tr>
<th>Body System</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUNG</td>
<td>Shortness of breath, wheezing, repetitive cough</td>
</tr>
<tr>
<td>HEART</td>
<td>Pale or blush skin, faintness, weak pulse, dizziness</td>
</tr>
<tr>
<td>THROAT</td>
<td>Tight or hoarse, trouble breathing or swallowing</td>
</tr>
<tr>
<td>MOUTH</td>
<td>Significant welling of the tongue or lips</td>
</tr>
<tr>
<td>SKIN</td>
<td>Hives over body, widespread redness</td>
</tr>
<tr>
<td>GUT</td>
<td>Repetitive vomiting, severe diarrhea</td>
</tr>
<tr>
<td>OTHER</td>
<td>Feeling something bad is about to happen, anxiety, confusion</td>
</tr>
</tbody>
</table>

**Epinephrine Auto Injector:** [ ] 0.15mg or [ ] 0.30mg  
**Call 911 if administered**

**Other medication to administer:**
- Medication: _________________________ Dose: __________  Frequency: __________
- Medication: _________________________ Dose: __________  Frequency: __________

#### MILD SYMPTOMS:

- **NOSE** | Itchy or runny nose, sneezing |
- **MOUTH** | Itchy mouth |
- **SKIN** | A few hives, mild rash |
- **GUT** | Mild nausea or discomfort |

**For MILD SYMPTOMS from more than one body system area GIVE EPINEPHRINE.**

**For MILD SYMPTOMS from a single system area follow the medication directions below:**

**Medications to administer:**
- Medication: _________________________ Dose: __________  Frequency: __________
- Medication: _________________________ Dose: __________  Frequency: __________

This student has been instructed on his/her symptoms and when and how to administer Epinephrine Auto Injector.

[ ] Self Carry  [ ] Self Administer

- [ ] All food provided from home  
- [ ] My child may eat from the school meal program  
- [ ] Allergen safe lunch table  
- [ ] Snacks in class allowed if adult checks packaging for allergen safety  
- [ ] Other: __________________

**Parent Signature:** ___________________________  
**Date:** __________

**Medical Provider Signature:** ___________________________  
**Date:** __________  **Contact Phone #:** _______________

**District Nurse Signature:** ___________________________  
**Date:** __________

Reference SDE Guidelines for managing life threatening allergies for additional information

Form updated 5/16/19