Huron Valley Schools – Plan of Care (POC)
Allergy/Asthma Management

Bus Route #: _____

Student Name: _____ School: Grade:

The student's asthma and _____ allergy can be life threatening. Signs of an allergic reaction and asthma episode may include the following: (items checked are ones usually experienced by the student)

Signs of an allergic reaction include:	Signs of an asthma episode include:
*Mouth: ☐ Itching and Swelling of the Lips ☐ Tongue ☐ Mouth *Throat: ☐ Itching ☐ Sense of Tightness in the Throat ☐ Hacking Cough Skin: ☐ Hives ☐ Itchy Rash ☐ Swelling about the Face or Extremities Gut: ☐ Nausea ☐ Abdominal Cramps ☐ Vomiting ☐ Diarrhea *Lung: ☐ Shortness of Breath ☐ Repetitive Coughing ☐ Wheezing *Heart: ☐ Thready Pulse ☐ Fainting	☐ Coughing ☐ Wheezing ☐ *Difficulty Breathing, Walking, Talking ☐ *Blue or Grey Discoloration of Lips or Fingernails ☐ *Increased Anxiety ☐ Other If the student experiences the above symptoms 1. Calm student 2. Encourage slow, deep breathing exercises 3. Give medication_____ (Doctor, please indicate type of medication above) 4. Stay with student fifteen (15) minutes. 5. Send back to class if improved status. 6. Contact Parents.

The severity of the above symptoms can quickly change. Above symptoms can potentially progress to a life-threatening status.

If the student suspects that an allergic reaction is happening or if the student experiences any feeling of the throat closing:

Treat as a MAJOR Reaction:

- **Inject one Epi-Pen immediately into the student's upper outer thigh**
- **Call 911**
- **Monitor closely until help arrives**

Call Parents: Home Phone: _____

Mother: _____Cell Phone: _____Work Phone:_____

Father: _____Cell Phone: _____Work Phone: _____

In the event that special accommodations are required, the school district may need up to five (5) school days to comply with the request. It will be up to the parent and the physician to determine if the child shall attend school during that time.

_____ _____ _____ _____

PARENT SIGNATURE DATE PHYSICIAN SIGNATURE DATE

Physician Name_____

Physician Address_____

Physician Phone_____

NOTE: This plan will be shared with all appropriate school district staff