



Jefferson City Schools - Student Health Services

Allergy Emergency Health Management Plan

School Year: _____

Student Name:	DOB:	Age:
School:	Teacher:	
Mother:	Father:	
Home:	Home:	
Work:	Work:	
Cell:	Cell:	
Hospital Preferences:		

Allergic to: _____

Symptoms: _____

Epi Pen used: Never _____ Date used _____

History of Asthma: _____ Albuterol used _____ Kept at school _____

MILD/MINOR SYMPTOMS

Itchy, runny nose, sneezing OR Itchy Mouth OR Localized rash, a few hives OR Nausea, vomits 1 time

GIVE Antihistamine: _____ Dose: _____ (by mouth)

STAY with student and observe for worsening symptoms(if more than 1 symptom go to SEVERE)

NOTIFY parent.

SEVERE SYMPTOMS

Mouth: itching, swelling of lips and/or tongue fainting Skin: itching, hives, redness, swelling Heart: weak pulse, dizziness,

Throat: itching, tightness/closure, hoarseness Abdomen: vomiting, diarrhea, cramps Lung: shortness of breath, cough, wheeze

GIVE epinephrine injection BRAND: _____ Dose: _____ (give in the upper, outer thigh)

CALL 911 and notify parent****

OTHER (check if applicable):

- Give antihistamine _____ Dose _____
- Give inhaler _____ Dose _____

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:

- 1. I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self-administer _____ (medication name and dose).
- 2. This student should be allowed to carry this epinephrine auto-injector while at school and on the school bus. The student is not capable of administration of this medication _____ (medication name and dose).

Physicians Signature: _____ Date: _____

School Clinic: Copy of plan to be provided to Transportation Supervisor. Information about students and family is strictly confidential.

Parent Signature/Date _____

School Clinic Signature/Date _____