PHARR-SAN JUAN-ALAMO INDEPENDENT SCHOOL DISTRICT

Severe Allergy Care Plan for School Year _____

- - - Plan must be renewed each school year - - -

Student's Name: _____ Student ID: _____

Date of birth: _____ Grade: _____ Teacher: _____

TO BE COMPLETED BY PHYSICIAN

ALLERGIC TO	**Specific Allergen(s)**
☐ Food ☐ Insect ☐ Other ☐ Latex ☐ Medication	
History of Asthma ☐ No ☐ Yes (higher risk for severe reaction)	
Food Allergy: Special Diet form **must** be completed if a special diet is to be provided at school	

MEDICATIONS (home AND school)	Name of Medicine	Dose	Frequency/Time	Give at School
ROUTINE Medication(s)				
EMERGENCY Medication(s)	**Epinephrine**:			
	Antihistamine:			

☐ YES
☐ NO

It is my professional opinion that this student should be allowed to carry and self-administer the *EPINEPHRINE* listed above while on school property or at school-related events. I have instructed the student in the proper way to use the medication and when to request antihistamine. The student is both capable and responsible for self-administering and caring for the epinephrine.

GREEN ZONE – *Prevention* • No symptoms	☐ Give *ROUTINE* medications that need to be given at school every day (see above) ☑ Avoid known allergens at school
YELLOW ZONE – *Caution!* **Mild Symptoms** • MOUTH: itchy • SKIN: a few hives around area of contact • GUT: mild nausea/discomfort	☐ Give **ANTIHISTAMINE** (see above) ☐ If symptoms progress to **Severe**, inject **EPINEPHRINE** (see above) ☑ Notify parent/guardian of student's status ☑ Once symptoms are relieved, student may return to class
RED ZONE – *Emergency!* **Severe Symptoms** • LUNG: short of breath, wheezing, repetitive cough • HEART: pale, blue, faint, weak pulse, dizzy, confused • THROAT: tight, hoarse, trouble breathing/ swallowing • MOUTH: obstructive swelling (tongue and/or lips) • SKIN: many hives over body, itchy rashes, swelling • GUT: vomiting, diarrhea, crampy pain • **Combination** of symptoms from different body areas	☐ Inject **EPINEPHRINE IMMEDIATELY** (see above) ☐ Call 9-1-1; request an ambulance with epinephrine ☐ Also give _____ *(include dose and frequency)* ☐ Repeat **EPINEPHRINE** after 5 minutes if symptoms persist or recur ☑ Notify parent/guardian and school administrator after calling 9-1-1 ☑ Treat for shock if needed (lying on back with legs raised) ☑ Stay with student until help arrives

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely contacted.

☐ If checked, give epinephrine immediately if the allergen was definitely contacted, even if no symptoms are noted.

Physician's Name (print): _____ Phone: _____

Physician's Signature: _____ Date: _____

Address: _____ City/Zip: _____