Muscogee County School District
Student Health Services
SEVERE ALLERGIC REACTION STUDENT HEALTH CARE PLAN

Please bring or mail this care plan to the school.
A new health care plan is required every school year.

Student: _____Date of Birth: _____School year: _____

School: _____Teacher: _____Grade/Team: _____

ALLERGY: _____**Asthmatic ☐ YES* ☐ NO**
**Higher risk for severe reaction*

♦ STEP 1: TREATMENT ♦

For the following symptoms:	**Give checked Medication**
NO SYMPTOMS, but ingestion or in contact with allergen	□ Epinephrine □ Antihistamine
MOUTH: Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine
SKIN: Hives, itchy rash, swelling of face or extremities	□ Epinephrine □ Antihistamine
GUT: Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine
♦ THROAT: Tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine
♦LUNG: Shortness of breath, repetitive coughing, wheezing	□ Epinephrine □ Antihistamine
♦HEART: Thready pulse, low BP, fainting, pale, blueness	□ Epinephrine □ Antihistamine
♦OTHER:	□ Epinephrine □ Antihistamine

♦*Potentially life-threatening symptoms*

SEVERAL of the above areas affected and reaction progressing	□ Epinephrine □ Antihistamine

DOSAGE OF MEDICATION

	Medication Name/Dose/Route
Epinephrine (inject intramuscularly)	□ EpiPen® □ EpiPen®Jr. □ Twinject ™ 0.3 mg □ Twinject™ 0.15 mg
Antihistamine (orally)	
Other	

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

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♦ STEP 2: EMERGENCY CALLS ♦

1. **Call 911**. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. **Physician:**_____ Phone Number: _____
3. **Emergency Contacts**

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Primary / Allergy Healthcare Provider:		**Phone Number:**	

*******DO NOT HESITATE TO MEDICATE OR CALL 911 even if Parents or Physician CANNOT be reached.*******

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written authorized orders
- ☐ Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____Phone Number: _____

Physician's Signature: _____ Date: _____

Parent Consent for Management of Allergy at School

I _____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's allergy and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature: _____Date: _____