District Health Services

Allergy Health Care Plan

(*Please attach picture to Care Plan)

Student Name: _____ **Date of Birth**: _____

Teacher: _____ Grade: _____School: _____

ALLERGY TO: _____

□ ***Box checked indicates a severe allergy which may lead to anaphylaxis.***

Asthmatic Yes*□ No □ *Higher risk of severe reaction *Inhaler at school? Yes___ No ___ Carries___

STEP 1: TREATMENT

Symptoms:	Give Checked Medication**: **(To be determined by physician authorizing treatment)
If an allergen has been exposed, but *no symptoms*:	□ Epinephrine □ Antihistamine
Mouth* Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine
Skin: Hives, itchy rash, swelling of the 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 blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine
Other* _____	□ Epinephrine □ Antihistamine
If reaction is progressing (several of the above areas affected),	□ Epinephrine □ Antihistamine

*** Allergies are potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY MEDICATION DOSAGE:

☐ EpiPen® dose:_____ ☐ Auvi Q dose: _____ ☐ Symjepi dose:_____

☐Other: medication/dose/route:_____

Antihistamine: give_____

medication/dose/route

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

STEP 2: EMERGENCY CALLS

Call 911 or Rescue Squad

*State that an allergic reaction has been treated and additional Epinephrine may be needed.

I am the parent/guardian of _____ and request that the Allergy Health Care Plan be utilized during school hours.
School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Allergy Health Care Plan authorizes District Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Parent Signature _____ Date: _____

Parent Name (Print) _____Phone # _____

Received by _____Date:_____

Date Reviewed by Cluster Nurse/Special Education Nurse: _____

Cluster Nurse/Special Education Nurse Signature: _____