



# Student Health Services

## Allergy Health Care Plan

(\*Please attach picture to Care Plan)

### Where Students Come First

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:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. /Auvi Q 0.1 mg Auvi Q 0.15mg Auvi Q 0.3 mg

Antihistamine: give \_\_\_\_\_ medication/dose/route

Other: 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 Student 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: \_\_\_\_\_