Lee County Schools / Student Health Services

ALLERGY/ANAPHYLAXIS CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 229-903- 3989

Student Name _____ **D.O.B.** _____ **Teacher** _____ **School Year** _____

History of *Asthma* | No | Yes (higher risk for severe reaction)

History of *Anaphylaxis* | No | Yes

ALLERGY: (check appropriate): **to be completed by Health Care Provider**

- **Medications (**list**):**_____
- **Latex - *Circle one:*** **Type I** (anaphylaxis) **Type IV** (contact dermatitis)
- **Stinging Insects (**list**):** _____

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED Medication**	
If contact w/ allergen occurs:		EpiPen	Antihistamine
No symptoms noted	☐ Observe for other symptoms		
Mouth +	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut +	Nausea, abdominal cramps, vomiting, diarrhea		
Throat +	Tightening of throat, hoarseness, hacking cough		
Lung +	Shortness of breath, repetitive coughing, wheezing		
Heart +	Thready pulse, low BP, fainting, pale, blueness		
Neuro +	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change.		***+ Potentially life-threatening***	

DOSAGE:

Epinephrine: Inject into outer thigh | **EpiPen 0.3 mg** OR **EpiPen Jr 0.15 mg**

Antihistamine: Benadryl _____ **mg** To be given by mouth o*nly if able to swallow*

Other: _____

Check appropriate box below:

- ☐ This child has received instruction in the proper use of the EpiPen. It is my professional opinion that this student **SHOULD** be allowed to carry and use the EpiPen independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.
- ☐ It is my professional opinion that this student **SHOULD NOT** carry the EpiPen.

Physician Signature: _____ **Phone:** _____ **Date:** _____

I, this child's parent/guardian, hereby authorize the named Health Care Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's severe 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 Portability 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 Lee County Schools. This authorization expires as of the last day of the school year.
I also agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto-injector.

Parent/Guardian's Signature*:* _____ **Date:** _____