



Individual Health Care Plan for Life Threatening Allergies

School Year: _____
Expires at end of current school year

Student Picture

Student Name: _____

DOB: _____ Weight: _____

Allergy to: _____

Had allergic reaction on the following date: _____ Required Epinephrine: ☐ Yes ☐ No

Describe reaction: _____ Has asthma: ☐ Yes ☐ No

SEVERE SYMPTOMS:



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body system areas

Epinephrine: Route: _____ Dose: _____ Frequency: _____ Call 911 if administered

Other medication to administer: Medication: _____ Route: _____ Dose: _____ Frequency: _____

Medication: _____ Route: _____ Dose: _____ Frequency: _____

MILD SYMPTOMS:



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild rash



GUT

Mild nausea or discomfort

For MILD SYMPTOMS from more than one body system area **GIVE EPINEPHRINE.**

For MILD SYMPTOMS from a single system area follow the medication directions below:

Medications to administer: Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

☐ This student has been instructed on his/her symptoms and when and how to administer Epinephrine Auto Injector.

☐ Self Carry ☐ Self Administer

☐ All food provided from home ☐ My child may eat from the school meal program ☐ Allergen safe lunch table

☐ Snacks in class allowed if adult checks packaging for allergen safety ☐ Other: _____

Parent Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____ Contact Phone #: _____

District Nurse Signature: _____ Date: _____