Fulton County Schools
Where Students Come First

Student Health Services

Allergy Care Plan

Student Name _____ D.O.B_____ Teacher_____

School_____ Grade_____ *(Please attach picture to Care Plan)*

ALLERGIC 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
Lungs: 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 0.15mg 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

1. Call 911 or Rescue Squad: _____.
State that an allergic reaction has been treated and additional Epinephrine may be needed.
2. Physician Full Name:_____ Office Phone: _____
3. Emergency Contacts: Name/Relationship Phone Number(s)
a. _____ 1._____ 2. _____
b. _____ 1._____ 2. _____
c. _____ 1._____ 2. _____

Parent/Guardian Signature _____ Date_____

Physician Name (*print legibly*) _____Signature_____ Date_____
(Physician signature required)

Date Received:_____ Cluster Nurse/Special Education Nurse Signature:_____