



District 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 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: _____