Severe Allergy Care Plan

(must be completed by a licensed health professional)

Student Name_______________________________________ Birth date______________

Grade _______________ Teacher ____

Severe ALLERGY to _________________________________ Routine medications ____

Other allergies ____

Asthmatic? (High risk for severe reaction): ___ Yes ___No   Date of Last Reaction ____________________________________

Please list the specific symptoms the student has experienced in the past:

____

Action Plan

If you suspect a severe allergic reaction to bees or food, immediately determine the symptoms and treat the reaction as follows:

Symptoms	(known symptoms X)		Give Medication	(x)
☐ Mouth	Itching, tingling or swelling of the lips, tongue or mouth		Antihistamine ☐	Epipen ☐
☐ Skin	Hives, itchy, rash and/or swelling about the face or extremities		Antihistamine ☐	Epipen ☐
☐ Throat	Sense of tightness in the throat, hoarseness and hacking cough		Antihistamine ☐	Epipen ☐
☐ Gut	Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea		Antihistamine ☐	Epipen ☐
☐ Lung	Shortness of breath, repetitive coughing and/or wheezing		Antihistamine ☐	Epipen ☐
☐ Heart	“Thready” pulse, “passing out”, fainting, blueness, pale		Antihistamine ☐	Epipen ☐
☐ General	Panic, sudden fatigue, chills, fear of impending doom		Antihistamine ☐	Epipen ☐
Other: ____			Antihistamine ☐	Epipen ☐
If food allergen has been ingested, but no symptoms. Other:______________________			Antihistamine ☐	Epipen ☐
If exposure to allergen other than by ingestion (i.e. skin, inhalation)			Antihistamine ☐	Epipen ☐
If a reaction is progressing (several of the above areas affected)			Antihistamine ☐	Epipen ☐
Asthma? Yes ☐ No ☐				
If only lung symptoms are present without known triggers of asthma or suspected ingestion, first give:		Fast acting inhaler ☐	Antihistamine ☐	Epipen ☐
If only inhaler is given and lung symptoms are not relieved within minutes:		Repeat inhaler ☐	Antihistamine ☐	Epipen ☐

911 must be called if Epipen administered

Medication Doses

Antihistamine _________________________________ Dose _______ Teaspoons ________ Tablets by Mouth ________

Epipen (.03) _________ Epipen Jr. (0.15) ___________ Side effects: ____

Repeat dose of Epipen: Yes ☐ No ☐ If yes, when:____

* **DO NOT HESITATE** to administer Epipen and to call 911 even if the parents cannot be reached.

This student may carry his/her own Epipen or inhaler *(please check)* ☐

I approve of the above orders.

* ____ ____________________ ____________________

(Physician’s Signature) (Start Date) (End Date)

Student Name: ____________________________________

Care Plan/Order for Severe Allergy – Part 2

- Student should remain quiet with the nurse or staff member until EMS arrives.
- Notify the administrators and parent/guardian.
- Provide a copy of the Emergency Care Plan to EMS upon arrival

Individual Considerations

Field Trip Procedures – Epipen and allergy plan will accompany student during any off-campus activities

- The student should remain with the group leader during the entire field trip ☐ Yes ☐ No
- Other ____
- Staff members on trip will be trained regarding Epipen use and this health care plan

School Meals (please check all that apply)

☐ Student will sit at a specified allergy table.
☐ Alternative snacks will be provided by the parent/guardian to be kept: ☐ Classroom ☐ with the Nurse
☐ Snacks in manufacturer's packing with ingredients listed and determined allergy-free by the nurse/parent are permissible.
☐ NO restrictions

Classroom activities (please check if applicable)

☐ Class projects should be reviewed by the teaching staff to avoid specified allergens.

Emergency Contacts

Mother/Guardian	Father/Guardian
Name	Name
Home Phone	Home Phone
Work Phone	Work Phone
Other	Other

Additional Emergency Contacts

1.	Relationship:	Phone:
2.	Relationship:	Phone:

Parent signature gives permission for school staff, that have been medication trained by the nurse, to administer prescribed medicine and gives permission to contact physician, if necessary.

My child may carry his/her own Epipen or inhaler *(please check)* ☐

*____ ______________________________
(Parent/Guardian Signature) (Date)

A copy of the Allergy Care Plan will be kept in the nurse's office and available to all staff members who are involved with the student.