Severe Allergy To: _____

Place Child's Picture Here

Student's Name_____ Grade_____ DOB_____

Parent Name_____

Phone: Home_____ Work_____ Cell_____

Emergency Contact_____ Phone_____

Doctor's Name_____ Phone_____

Local Hospital_____ Phone_____

Asthmatic: Yes No (Higher risk for severe reaction if yes)

To be completed by Physician

MINOR SYMPTOMS:

- Swelling at site of insect sting or from contact with allergen
- Several hives
- Itchy skin
- Ingestion/sting is suspected

TREATMENT:

1. Send student to health office ACCOMPANIED.
2. Give by mouth_____ of _____.
   (amount and dosage:) (antihistamine)
3. Contact the parent or emergency contact person.
4. If exposed, have child wash face, hands and exposed area.
5. Stay with the student. Monitor symptoms, until parent arrives.
   Watch student for more serious symptoms listed below.

SEVERE SYMPTOMS:

- Wheezing, difficulty swallowing/breathing
- Swelling (face, neck), tingling/swelling of the tongue, throat feels like its closing
- Vomiting
- Increase in the number of hives
- Anxiety, confusion

TREATMENT:

1. Give:_____ Epi-Pen Jr.® OR_____ Epi-Pen® immediately
   (under 66lbs) (66lbs & over)
2. Call 911 (or local emergency response team) immediately.
3. Epi-pen® only lasts 20-30 minutes.
   ****Paramedics should always be called if Epi-Pen® is given****
4. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.

Student:_____ Teacher/Team_____

HISTORY: When was the allergy first diagnosed: _____

_____

Type of reaction experienced: _____

_____

Date of last reaction and necessary treatment: _____

_____

Medications taken at home: _____

_____

DIET RESTRICTIONS FOR FOOD ALLERGY:

Parents will monitor school lunch menus or provide food
Student will self monitor food choices
Student needs to sit at an allergy free table
Student can sit with their class at the lunch table

DIRECTIONS FOR USE OF EPI-PEN:

1. Pull off gray cap.
2. Place black tip against upper outer thigh. Can give through clothes if needed.
3. Press hard into outer thigh until it clicks.
4. Hold in place 10 seconds and then remove.

If symptoms don't improve after _____ minutes, administer second dose following steps 1-4 above.

If _____ experiences a change in health condition (such as a change in medication or hospitalization,) please contact the School Nurse so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed on page 1, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature_____ **Date**_____

Doctor Signature_____ Date_____

School Nurse Signature_____ Date_____